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EXPIRING MEDICARE PROVIDER PAYMENT POLICIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

SEPTEMBER 21, 2011

Serial No. 112–HL6

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

72–281 WASHINGTON : 2011

For sale by the Superintendent of Documents, U.S. Government Printing Office
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EXPIRING MEDICARE PROVIDER PAYMENT PROVISIONS

WEDNESDAY, SEPTEMBER 21, 2011

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to call, at 2:01 p.m., in Room 1100, Longworth House Office Building, Honorable Wally Herger [Chairman of the Subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Chairman Herger Announces Hearing on Expiring Medicare Provider Payment Policies

September 21, 2011

House Ways and Means Health Subcommittee Chairman Wally Herger (R–CA) today announced that the Subcommittee on Health will hold a hearing to examine certain expiring Medicare provider payment provisions. **The hearing will take place on Wednesday, September 21, 2011, in 1100 Longworth House Office Building, beginning at 2:00 P.M.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

There are a number of Medicare provider payment policies that expire on or before December 31, 2011. Many of these policies have been extended multiple times over several years, even if they were initially contemplated to be short-term or even one-time payment changes. The provisions touch many parts of the Medicare program. Often, Congress has simply changed the expiration date without actually closely examining whether the policy is still necessary or appropriate.

In light of the ongoing need to reduce the country's deficit, it is important to examine these payment policies to determine if further extensions are warranted. This hearing will allow provider groups to explain the impact each of the payment policies has and offer suggestions for improvements.

In announcing the hearing, Chairman Herger stated, **"With a likely price tag of a one year extension totaling more than $2.5 billion, the Subcommittee must ensure that taxpayers' money will be spent wisely. As Members of the Subcommittee on Health, we have an obligation to examine Medicare's payment policies to determine whether they are sound and justified."**

FOCUS OF THE HEARING:

The hearing will focus on certain expiring Medicare provider payment provisions and the impact these provisions have on health care providers.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov,* select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, by the close of business on Wednesday, October 5, 2011. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman HERGER. The subcommittee will come to order.

Today, we are going to hear about a number of Medicare provider payment provisions that will soon expire unless Congress intervenes. But just because Congress must act does not mean it should do so blindly.

This hearing offers us, and more importantly the American people, a chance to consider whether Congress should spend more than $2 billion to reauthorize these additional payments for another year. Just as importantly, it affords interested parties the opportunity to make their case as to whether or not these payments should continue.

In undertaking this review, I am hopeful that we can learn whether or not these payment policies, some of which are more than a decade old, are in need of reform or can be allowed to expire and become the temporary policies they were originally intended to be.

When these policies were created, many were billed as short-term or one-time payment adjustments. However, Congress has extended most of them on an annual basis for the last decade. In most cases, the payments have simply been extended five times or more without any changes to the underlying policy. Often Congress has reauthorized these provider payments in the "doc fix" bills which, unfortunately, more often than not pass late in the year, af-

fording us little time to examine the policies and determine if they are still serving their intended purpose.

It is my hope that by beginning to closely study these provisions now, Members of the Subcommittee will have ample time to learn about these policies and whether they are worthwhile for providers and beneficiaries.

The witnesses appearing before us this afternoon are well positioned to explain these provisions, as they represent the very providers who benefit from these additional payments. In some cases, the witnesses themselves continue to work as providers in their given field. I welcome their testimony and trust it will offer members an in-depth look at each of the expiring provisions and its impact on the affected provider groups.

I am encouraged that some members of our panel will offer a recommendation for ways Congress can improve these policies. And I thank them for being forward thinking. I believe such reforms are long overdue, given that some of these policies date back to 1997 and have never been updated. I am especially pleased that several witnesses will share their ideas as to how Congress could offset the cost of extending these policies.

We will also hear from a former GAO official who will encourage members to consider whether these additional payments actually benefit Medicare beneficiaries. It is important that we hear this side of the story as well because at the end of the day, we must ensure that the policies we support have a positive impact on seniors, especially since many of them result in higher premiums.

It is important to keep in mind that extending these provisions cost money, more than $2 billion every year they are reauthorized. As Members of Congress, we have been entrusted with the enormous responsibility of being good stewards of the taxpayers' hard-earned dollars. A $100 million extension may not seem expensive in the context of a Medicare program that spends more than one-half trillion dollars every year, but it is a large sum of money nonetheless. History shows that Congress has continued to extend these policies year in and year out, which raises the question: Given that these additional payments do not appear to be temporary, isn't the true cost of the annual $2 billion extender package actually $25 billion when measured over Congress' standard 10-year budget window?

Today more than ever, Congress must show fiscal responsibility both in what is passed and how it is passed. We simply cannot afford to continue spending money we do not have in a program that is going bankrupt.

Before recognizing Ranking Member Stark, I ask unanimous consent that all members' written testimony be included in the record.

Without objection, so ordered.

I now recognize Ranking Member Stark for 5 minutes for the purpose of his opening statement.

Mr. STARK. Thank you, Chairman Herger, for holding this hearing to review the provider extenders. I would note that there are a couple of provisions that help low-income people that also need extension at a cost of a couple of billion dollars and is not part of today's meeting.

But looking at the entire package, some of those provisions, like therapy cap exception and the continuation of the QI program, ensure critical access to needy Medicare beneficiaries. Other provisions were enacted to address a perceived payment problem for a particular provider at a particular time. And I look forward to hearing our witnesses' thoughts on which of these provisions fit into which categories.

Extenders are generally written on legislation preventing a pending cut in physician payment due to the broken Medicare payment formula, or SGR, as it has been called here. I would be curious also to hear from the witnesses today their thoughts on the role of the new supercommittee for deficit reduction and what role they will play as we work to resolve SGR and other extenders.

I would argue that the Medicare savings that we are able to find should first go to fix shortcomings in Medicare and not just get dumped into the general pot. Paying physicians fairly is important to the future of the program. There may be specific extenders needed to preserve beneficiary access. So we need to learn exactly what payment changes to the delivery system before we take more money out of the system and we need to resolve Medicare savings before the savings leave the program.

I will ask each of the witnesses in their remarks for their comments on what we should do with these savings.

I thank you again. I thank the witnesses for joining us today.

I yield back the balance of my time.

Chairman HERGER. Thank you, Mr. Stark.

Today, we are joined by five witnesses who will discuss the details of each of the expiring Medicare provider payment policies. We will hear both the pros and the cons of extending these policies. Our witnesses in the order they will testify are Rich Umbdenstock, president, American Hospital Association; Steven Williamson, president, American Ambulance Association; Dr. Robert Wah, chairman, Board of Trustees, American Medical Association; Justin Moore, vice president of Government Affairs, American Physical Therapy Association; and Bruce Steinwald, president, Steinwald Consulting.

You will each be recognized for 5 minutes.

Mr. Umbdenstock, will you begin, please.

STATEMENT OF RICH UMBDENSTOCK, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, WASHINGTON, D.C.

Mr. UMBDENSTOCK. Thank you very much.

Good afternoon, Chairman Herger, Ranking Member Stark, distinguished Members of the Subcommittee. I am Rich Umbdenstock, president and CEO of the American Hospital Association. On behalf of our more than 5,000 hospital members, health systems, and other health care organizations, and our 42,000 individual members, the AHA appreciates the opportunity to testify regarding certain expiring Medicare provider payment provisions and their importance to Medicare beneficiaries. And we applaud the committee for holding this meeting.

Over the years, Congress has enacted several provisions to address the special challenges rural hospitals encounter in delivering health care services to the communities they are committed to serve. The AHA urges the committee to recognize that the circumstances that made those provisions necessary still exist. And so does the need for these provisions.

I would like to focus on three areas in particular: Section 508 hospital classifications, outpatient hold harmless provisions, and lab services for rural hospitals.

First, the area wage index is greatly flawed in many respects. It is highly volatile from year to year; self-perpetuating, in that hospitals with low-wage indices cannot increase wages to become competitive in the labor market; and they are based on unrealistic geographic boundaries. Section 508 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 allows about 100 qualifying hospitals to receive wage index reclassifications and assignments that provide them with the resources to attract and retain the workforce they need to best serve their beneficiaries. Its provisions will expire October 1 of this year, and we believe it should be extended.

Second, Congress made certain rural hospitals with 100 or fewer beds eligible to receive an additional payment known as hold harmless transitional outpatient payments, or TOPs. TOPs were meant to ease these hospitals' transition from the prior reasonable cost-based payment system to the outpatient prospective payment system. Concerned about the financial stability of these small rural hospitals, Congress extended the provision each year and has also expanded it to vulnerable sole-community hospitals. Hospitals that receive TOPs have Medicare payments averaging only about 82 percent of their costs. If this provision expires, that figure will go down to 75 percent of their costs. We urge Congress to extend and make these payments permanent before they expire at the end of this year.

Third, despite their small size and smaller patient base, hospitals in qualified rural areas, or so-called super rural communities, still have to maintain a broad range of basic services to meet the health care needs of their communities. These include laboratory services. And hospitals may be the only source of these critical services for many miles. The Medicare Modernization Act of 2003 included a provision requiring reasonable cost reimbursement for outpatient clinical laboratory tests furnished by hospitals with fewer than 50 beds in these qualified rural areas. The Accountable

Care Act and the Medicare and Medicaid Extenders Act reintroduced and extended these provisions, but they are now due to expire on June 30, 2012.

In the absence of these provisions, reimbursement for hospital outpatient clinical lab services in these super rural communities would revert to rates under the clinical laboratory fee schedule. The AHA recommends that Congress permanently extend the application of reasonable cost reimbursement methodology for hospital outpatient clinical laboratory services in these communities.

We also support allowing independent laboratories to continue to bill separately for the technical component of physician pathology services furnished to patients in hospitals with existing "grandfathered" agreements with independent laboratories. These hospitals would otherwise have to set up expensive and burdensome billing arrangements in order to pay the independent labs directly for their services, despite the fact that the Medicare hospital payments do not incorporate payment for these kinds of technical component services.

More detail on each of these requests and recommendations and additional areas of concern to the AHA is provided in my testimony. I thank the committee for your attention today. I hope you will recognize the unique challenges of delivering quality health care in rural areas by extending these expiring Medicare provider payment provisions.

Thank you very much.

[The prepared statement of Mr. Umbdenstock follows:]

**THIS TESTIMONY IS EMBARGOED
UNTIL 2:00 PM ON
WEDNESDAY, SEPTEMBER 21, 2011**

American Hospital
Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

Testimony

of the

American Hospital Association

before the

Committee on Ways and Means,

Subcommittee on Health

of the

United States House of Representatives

"Expiring Medicare Provider Payment Provisions"

September 23, 2011

Good morning, Mr. Chairman and distinguished members of the Committee. I am Richard Umbdenstock, president and CEO of the American Hospital Association (AHA). On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the AHA appreciates the opportunity to testify regarding certain expiring Medicare provider payment provisions and their importance to Medicare beneficiaries, and we applaud the Committee for holding this hearing.

SECTION 508

The area wage index is greatly flawed in many respects. It is highly volatile from year to year, is self-perpetuating (in that hospitals with low wage indexes are unable to increase wages to become competitive in the labor market) and is based on unrealistic geographic boundaries. These fundamental problems warrant a full and comprehensive re-evaluation and redesign of a system that CMS itself acknowledges is burdensome and of questionable integrity.

In an attempt to introduce more equity into a system that is so flawed, certain exceptions to the wage index have been created. One example is Section 508 of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003*, which allows certain qualifying hospitals to receive wage index reclassifications and assignments that they otherwise would not have been eligible to receive. About 100 hospitals are reclassified under Section 508. The program was originally effective for discharges beginning April 1, 2004, and ending March 31, 2007, but has been extended several times and is now scheduled to end October 1, 2011.

The Section 508 program provides critical help to hospitals with wages that are not representative of their area, but that slip through the cracks of the current reclassification criteria. Specifically, many hospitals apply each year to the Medicare Geographic Classification Review Board (MGCRB) for reclassification to another area to receive a higher area wage index. The current criteria for reclassification require a hospital to be in close geographic proximity to the area to which it wants to reclassify and to have wages that are a certain amount higher than hospitals in its own area, but comparable to the hospitals in the area to which it seeks reclassification. The 508 criteria were designed to accommodate categories of hospitals that, based on CMS experience, fall just beyond the current regulatory reclassification criteria. The program provides them with the resources necessary to be able to attract and retain a sufficient workforce and best serve their beneficiaries.

LOW-VOLUME ADJUSTMENT

The ACA improved the low-volume adjustment for fiscal years 2011 and 2012. 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 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. About 500 hospitals are receiving the low-volume adjustment in FY 2011.

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 where providers frequently cannot achieve the economies of scale possible for their larger counterparts. Although a low-volume adjustment had existed in the inpatient prospective payment system (PPS) prior to FY 2011, CMS had defined the eligibility criteria so narrowly that only two to three hospitals qualified each year. The 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. Additionally, 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. 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.

OUTPATIENT HOLD-HARMLESS PAYMENTS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS

When the outpatient prospective payment system (OPPS) was implemented, Congress made certain rural hospitals with 100 or fewer beds eligible to receive an additional payment adjustment, referred to as "hold harmless" transitional outpatient payments (TOPs). "Hold harmless" TOPS were intended to ease their 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 every year since and has subsequently expanded it to apply to equally vulnerable sole community hospitals (SCHs).

Under this 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 2010, 258 small rural hospitals and SCHs received $93.7 million in "hold harmless" TOPs[i]. Due to the expiration of legislative authority, these hospitals will cease to be eligible for TOPs on December 31, 2011.

The AHA 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. 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 TOPs already have Medicare payments that are well below their Medicare costs, with payments averaging about 82 percent of costs. By contrast, other hospitals have a significantly higher payment-to-cost percentage – about 91 percent. In fact, 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 would see their payment-to-cost percentage plummet 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 vulnerable

hospitals to continue to provide access to critical outpatient services, such as emergency department services and chemotherapy.

PAYMENT FOR THE TECHNICAL COMPONENT OF PHYSICIAN PATHOLOGY SERVICES FURNISHED TO HOSPITAL PATIENTS

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 and rural hospitals, 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 IN SMALL HOSPITALS LOCATED IN QUALIFIED RURAL AREAS

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 sparsely populated rural areas. Despite their small size and their smaller base of patients, these hospitals still have to maintain a broad range of 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 miles. Laboratory tests provide critical information on which sound medical decisions can be made. It has been estimated that 70 percent of all medical decisions are based on laboratory testing.

Congress initially enacted reasonable cost reimbursement for outpatient clinical lab tests in these small rural hospitals because they have fewer patients over which to spread fixed expenses and therefore costs per case tend to be higher. Payment under the CLFS is clearly inappropriate for these extremely vulnerable hospitals. Clinical laboratory testing has been subject to significant payment freezes and cuts over the last decade. Medicare payment amounts for clinical laboratory services have been reduced by about 40 percent in real (inflation-adjusted) terms over the past 20 years. In fact, since 1997, CLFS payments have been increased only twice, in 2003 (by 1.1 percent) and 2009 (by 4.5 percent). As required by legislation, in 2010 and 2011 the CLFS payments were actually reduced, by 1.9 percent and 1.75 percent, respectively. The laboratory-specific cut and the productivity adjustment included in the ACA is estimated to result in a cumulative 20 percent cut over 10 years.

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 seniors whose health depends on lab testing. 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.

AMBULANCE ADD-ONS 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 ambulances 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 are in the lowest 25% in population density. Congress, in the *Medicare Improvements for Patients and Providers Act* (MIPPA), raised this adjustment to 3 percent for rural ambulance providers.

Congress appropriately decided that these additional rural payments were necessary and important because rural ambulance providers incur higher per-trip costs because of longer travel distances and fewer transports of patients. These provisions ensure that ambulance services are more appropriately reimbursed and that beneficiaries in rural and super rural areas will have access to emergency transport services.

COST REDUCING POLICIES

As the Committee is examining these policies and their impact on costs and on Medicare beneficiaries, there are a number of proposals that AHA supports that would reduce Medicare spending and could be included in year-end Medicare legislation. While there are a number of policies AHA supports or is willing to discuss, including restructuring components of the Medicare program, I would like to specifically highlight long-term care hospital criteria, 340B drug pricing, and medical liability reform.

Long-Term Care Hospital Criteria

Establishing facility criteria for long-term care hospitals would both define the care delivered in these facilities as well as reduce costs to Medicare. S. 1486, the *Long-Term Care Hospital Improvement Act of 2011*, accomplishes this.

As you know, LTCHs provide hospital care for a specific patient population – medically complex, long-stay patients. LTCHs include both free-standing facilities and facilities co-located within hospitals, and treat a wide variety of conditions such as respiratory failure with ventilator dependency, infections, patients with complex wounds and trauma patients.

The Medicare Payment Advisory Commission and other policymakers have called for new LTCH patient and facility criteria as the best policy approach to ensure the right patients are treated in LTCHs. To do this, Congress should establish comprehensive patient and facility criteria to distinguish LTCHs from all other provider settings. S. 1486 was developed with carefully considered input from hospitals and clinicians who work in this medically complex area and would accomplish this goal.

The legislation implements patient criteria, facility criteria and the retrospective test to ensure that LTCHs are focused on treating high-acuity patients. The patient criteria standard ensures all potential LTCH patients are screened prior to admission through a standardized process that is overseen by a physician, with new patients examined by an LTCH physician during the first 24 hours to assess whether LTCH-level care is reasonable and necessary. The legislation's facility criteria would establish common requirements for the programmatic, personnel and clinical operations of an LTCH.

Additionally, LTCHs should demonstrate that 70 percent of LTCH cases meet criteria that demonstrate that LTCHs focus on treating medically complex patients and patients requiring extended stays.

In the absence of LTCH criteria, CMS instituted the "25% Rule" in 2004 to reduce access to LTCHs based on a patient's prior site of care. The 25% Rule is a blunt payment policy necessitated by the lack of criteria based on the clinical needs of patients; the very short-stay outlier (VSSO) policy and CMS's planned budget neutrality adjustment were in turn necessitated as blunt payment containment policies. This legislation replaces these policies with patient and facility criteria that clarify a specific and unique role for LTCHs in the continuum of care, ensure patients are admitted based on their medical needs, and bring uniformity and cost containment to the LTCH field.

Congress should support criteria that ensure LTCHs provide quality hospital care to the appropriate patients. Furthermore, in concert with establishing facility and patient criteria, Congress should repeal the 25% Rule, budget-neutrality adjustment, and VSSO policies. The Moran Company scored the proposal as saving $500 million over 10 years.

340B Drug Discount Program

In 1990, Congress established the Medicaid drug rebate program, which requires drug manufacturers to enter into and have in effect a rebate agreement with the Secretary of the Department of Health and Human Services. The rebate agreement requires that pharmaceutical manufacturers supply their products to state Medicaid programs at the manufacturer's "best price" – that is, the lowest price offered to other purchasers.

Section 340B of the *Public Health Service Act* expanded the program. It requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to taxpayer-supported health care facilities that care for uninsured and low-income people. Covered entities include community health centers, children's hospitals, hemophilia treatment centers, and public and nonprofit disproportionate share hospitals (DSH) that serve low-income and indigent populations.

The AHA supports extending the 340B discounts to the purchases of drugs used during inpatient hospital stays for safety-net hospitals. Many of these hospitals are in urban settings and are the health care safety net for their communities. This would allow these hospitals to further stretch their limited resources and relieve them of the burden of carrying two separate inventories and pricing structures for inpatient and outpatient drugs.

The AHA also supports extending the 340B drug program discounts to critical access hospitals (CAHs), sole community hospitals (SCHs), rural referral centers (RRCs) and Medicare-dependent hospitals for inpatient stays. Currently, CAHs, and SCHs and RRCs with a DSH adjustment equal to or greater than 8 percent are eligible for the outpatient discount. These hospitals serve low-income patients in rural areas by providing emergency and health care services and are the sole source of care for patients in their communities.

This program is a "win-win" for taxpayers, as well as for hospitals. The 340B program generates savings for the Medicaid program and also reduces Medicare costs, as CAHs are paid 101

percent of their inpatient and outpatient costs by Medicare, and the 340B pricing mechanism will lower their drug costs.

Medical Liability Reform

The high costs associated with the current medical liability system not only harm hospitals and physicians, but also patients and their communities. Across the nation, access to health care is being negatively impacted as physicians move from states with high insurance costs or stop providing services that may expose them to a greater risk of litigation. The increased costs that result from the current flawed medical liability system not only hinder access to affordable health care, they also threaten the stability of the hospital field, which employed 5.3 million people in 2009, and continues to be one of the largest sources of private-sector jobs.

An estimated $50 to $100 billion is spent annually on defensive medicine – services not provided for the primary purpose of benefiting the patient, but rather to mitigate the risk of liability. To help make health care more affordable and efficient, the current medical liability system must be reformed.

There are proven models of reform enacted in several states across the country, and in fact California's model has previously been the core of legislation passed by the United States House of Representatives. The AHA supports this legislation, H.R. 5, the *Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011*. This and other legislative proposals will likely be considered during this 112th session of Congress, and we applaud the work and leadership Members of this Committee have shown on the issue thus far.

Reduction of costs via medical liability reform will have a direct and indirect impact on Medicare payment on physicians: directly, the component of the Medicare physician payment rate formula that includes medical liability insurance will be reduced; also directly, as CBO has found when it scored H.R. 5 as saving $57 billion over 10 years, decreased utilization will yield a savings to the program. Indirectly, medical liability reform increases physician net income via reduced medical liability insurance costs, reduced individual (and practice) exposure to a liability judgment, and reduced time practicing defensive medicine thus freeing that time for other endeavors.

CONCLUSION

Over the years, Congress has enacted several provisions to address the special challenges rural hospitals encounter in delivering health care services to the communities they are committed to serving. The American Hospital Association urges the Committee to recognize that the circumstances that necessitated these provisions continue to exist, and therefore it is appropriate that they be extended.

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[i] The Congressional Budget Office estimate for the cost of this provision is $200 million. We believe that this amount is too high in that it erroneously takes into account hold-harmless TOPs payments for cancer hospitals and children's hospitals, which are accorded a permanent hold-harmless status under the Social Security Act. Our estimate is that the provision costs approximately $100 million.

Chairman HERGER. Thank you.
Mr. Williamson for 5 minutes.

STATEMENT OF STEPHEN WILLIAMSON, PRESIDENT, AMERICAN AMBULANCE ASSOCIATION, MCLEAN, VA

Mr. WILLIAMSON. Chairman Herger, Ranking Member Stark, and members of the House Ways and Means Subcommittee on Health, I greatly appreciate the opportunity to provide testimony today on the need to extend current Medicare ambulance relief. My name is Stephen Williamson. I am president of the American Ambulance Association. I am also president and CEO of Emergency Medical Services Authority for Tulsa and Oklahoma City.

Ambulance services are a crucial component of our local and national health care system. Ambulance service providers provide health care to patients regardless of their ability to pay. When there is an accident at home and a loved one is in need of medical care, we know to dial 911 and an ambulance will be on its way. In many smaller communities, the ambulance service provider is the only readily available access to emergency medical care.

Ambulance service providers are facing significant financial difficulty due in part to a Medicare ambulance fee schedule that is underfunded. In May of 2007, the Government Accountability Office found that ambulance service providers are paid 6 percent below cost and 17 below cost in remote areas to provide ambulance services to Medicare patients.

This is primarily the result of a structural flaw in the design of Medicare ambulance fee schedule. This error was especially damaging for the sector in which Medicare patients make up approximately 50 percent of the total patients served. Additionally, since the GAO report was released, Medicare reimbursement has been reduced by another 2 percent through a reduction in our inflation update and policy changes to CMS regarding payment for fractional mileage.

From the patient care side, ambulance service providers are rendering more sophisticated care. This improves patient outcomes and saves the Medicare program money but increases the cost to the ambulance service provider, which are not reimbursed.

Congress has recognized the challenges facing ambulance service providers and implemented Medicare ambulance relief. Ambulance service providers currently receive a temporary 2 percent Medicare increase for ground ambulance services that originate in an urban area; 3 percent in a rural area; and a 22.6 percent bump to the base rate in extremely remote or super rural areas. These increases have been crucial for an industry made up predominantly of small businesses that operate only slightly above the break-even point under the best of circumstances.

Medicare ambulance relief has meant that a majority of ambulance service providers can continue to provide quality health care. Medics are receiving training and new technologies and enhanced procedures that can make dramatic difference in the initial hours of critical care. Without relief, a number of providers will have to cut back on the number of medics, scale back their service area, or discontinue service. The immediate result is longer response times.

The American Ambulance Association recognizes the significant difficult financial decisions facing policymakers. Our association has taken a number of steps to ensure ambulance service providers are providing quality, efficient care to Medicare beneficiaries.

While our industry has one of the lowest payment error rate percentages, we are helping CMS to identify and root out waste and abuse in the Medicare program. We acknowledge that systematic reforms must also be considered to ensure the continued viability of the Medicare program and help reduce the deficit.

The American Ambulance Association notes the recent proposal released by the Health Care Leadership Council as worthy of consideration. It identifies the type of changes that are necessary to help achieve significant savings within Medicare which could be primarily used to offset ambulance and other provider relief. Two recommendations, the implementation of medical liability reform and the creation of Medicare exchange, have particular promise.

The current temporary Medicare ambulance relief is working exactly as intended. It is allowing the majority of ambulance service providers to maintain current levels of high-quality critically needed emergency and nonemergency ambulance service. The loss of relief, compounded by additional recent cuts in reimbursement, would change the delicate balance and negatively impact access to care, especially in the super rural areas. Extension of relief will result in better patient care and ensuring that an ambulance will respond quickly when you call 911.

I appreciate this opportunity to testify and would be happy to answer any questions you may have for me. Thank you.

[The prepared statement of Mr. Williamson follows:]

**THIS TESTIMONY IS EMBARGOED UNTIL 2:00 PM
ON WEDNESDAY, SEPTEMBER 21, 2011**

STATEMENT OF

**H. STEPHEN WILLIAMSON
PRESIDENT
AMERICAN AMBULANCE ASSOCIATION**

HEARING ON

EXPIRING MEDICARE PROVIDER PAYMENT POLICIES

BEFORE THE

**U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH**

SEPTEMBER 21, 2011

Chairman Herger, Ranking Member Stark and Members of the House Ways and Means Subcommittee on Health, I greatly appreciate the opportunity to provide testimony today on the need to extend current Medicare ambulance relief. My name is Stephen Williamson and I am the President of the American Ambulance Association (AAA) which is the trade association representing ground emergency and non-emergency ambulance service providers. In addition to being the President of the AAA, I am the President and CEO of Emergency Medical Services Authority which serves more than 1.1 million residents of Tulsa, Oklahoma City and surrounding areas with ambulance services.

Ambulance service providers currently receive a temporary 2% Medicare increase for ground ambulance services that originate in an urban area, 3% in a rural area and a 22.6% bump to the base rate in extremely remote or "super rural" areas. Medicare represents approximately 50% of the transports of an ambulance service provider which typically has fewer than six ambulances. The temporary increases therefore have been critical for an industry of predominately small businesses that under the best of circumstances operate only slightly above breakeven. The Government Accountability Office (GAO) confirmed this dire need for ambulance relief when it found that ambulance service providers are reimbursed by Medicare on average 6% below their costs as an industry and, even worse, 17% below cost in super rural areas.

For a majority of ambulance service providers, the temporary relief has made it possible to maintain adequate ambulance crew levels, stock ambulances with the proper supplies and continue to provide high quality and life saving ambulance services. However, with recent additional cuts in Medicare reimbursement, we are now finding even with the relief that ambulance service providers in some areas are laying off paramedics and emergency medical technicians (EMTs), scaling back services and unfortunately closing their doors. I therefore implore the Subcommittee to ensure that this critically needed temporary relief for ambulance service providers does not expire at the end of the year.

Ambulance Service Providers are America's Health Care Safety Net

Ambulance services are a critical component of our local and national health care and emergency response systems. Ambulance service providers respond to medical emergencies and provide health care to patients regardless of their ability to pay. When there is an accident at home and a loved one is in need of medical care, we know to dial 9-1-1 and an ambulance will be on its way. In many smaller communities, the ambulance service provider is the only readily available access to emergency medical care.

Ambulance service providers are also first responders both within their communities and on the national scene. Members of our association were involved with the response to the terrorist attack on the World Trade Center, evacuation of patients from Hurricane Katrina and were on the front lines during the recent flooding from Hurricane Irene in the Mid Atlantic and Northeast. Some of our members have traveled hundreds of miles to areas in need of medical help as a result of natural disasters. Adequate Medicare reimbursement directly influences not only response times and emergency medical services for the local community but for the nation as a whole.

Medicare Ambulance Fee Schedule Reimbursement is below Costs

The Medicare ambulance fee schedule has had inadequate funding since its inception which is why there is a need for relief. As part of the *Balanced Budget Act of 1997* (BBA), Congress directed the Centers for Medicare and Medicaid Services (CMS) to develop a fee schedule for Medicare reimbursement of ambulance services. As also directed in the BBA, CMS developed the fee schedule through the Negotiated Rule Making process allowing all stakeholders to participate. However, CMS could not use more money than what was already being spent on ambulance services for that year.

Prior to the implementation of the Medicare ambulance fee schedule in 2002, ambulance service providers had been reimbursed on a reasonable charge basis unlike most providers who were reimbursed based on costs. In some areas of the country, providers were able to work with their carriers to set rates that covered their costs. In most areas, however, providers were reimbursed well below their costs. At the time the rates for the ambulance fee schedule were set, there was therefore insufficient funding to ensure that rates were at least on average reimbursing providers at their cost.

Congress soon recognized the problem and enacted several temporary relief provisions in the *Medicare Modernization Act of 2003* (MMA). All of those provisions except for the "super rural" bonus payment for ambulance services in remote areas have expired. To determine how best to address a permanent fix to the Medicare ambulance fee schedule, as part of the MMA Congress requested that the GAO study the "cost, access, supply and quality of ambulance services" provided to Medicare beneficiaries.

In May of 2007, the GAO reported ambulance service providers are paid on average 6% below cost and 17% below cost in remote or "super rural" areas to provide ambulance services to Medicare patients. In the *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA), Congress provided temporary 2% urban and 3% rural increases to both the base rate and mileage rate for ambulance services. The 2% urban, 3% rural and "super rural" bonus payment increases have since been extended, most recently in the *Medicare and Medicaid Extenders Act of 2010*, and are set to expire on December 31 of this year. The Congressional Budget Office (CBO) has scored a one-year extension of Medicare ambulance relief at $100 million over ten years.

While the findings of the current GAO report are still extremely germane, we believe that the disparity between Medicare reimbursement and the cost of providing ambulance services has actually widened. Since the report was released, Medicare reimbursement has been reduced by approximately 2% through a reduction in our inflation update and a policy change by CMS regarding payment of fractional mileage. From the patient care side, ambulance service providers are rendering more sophisticated care which improves patient outcome. This costs more money for the ambulance service provider but often has downstream savings for the Medicare program.

Impact of Temporary Medicare Ambulance Relief

The temporary Medicare ambulance relief has meant that a majority of ambulance service providers can continue to provide high quality health care. With the additional funding, ambulance crews now deliver patients to emergency departments in far better condition than even just a few years ago. Paramedics and EMTs are receiving training in new technology and enhanced procedures. For the patient, it means decreased hospital stays and less need for tests and treatments that would otherwise have been required.

If the relief were to expire, ambulance service providers would not have the funding to invest in technology that saves lives such as equipment to diagnose patients experiencing heart attacks. The relief has allowed providers to purchase equipment and train paramedics and EMTs to send while in transport vital information about a potential heart attack victim to doctors in the emergency department. The ambulance crew can quickly confirm that it is indeed a heart attack, begin the proper life saving treatment, send valuable information to the doctor, and transport the patient to a hospital that specializes in treating heart attack patients. This investment is thus saving more lives and preventing costly and unnecessary open heart surgery.

While the relief is enabling some providers to invest in new technology, other providers rely on the funding to maintain current service by helping pay the salaries of paramedics and EMTs and repairs for ambulances. Without the relief, some providers would have to cut back on the number of ambulance crews, scale back their service area or discontinue service altogether. This has already been demonstrated when ambulance service providers in Oregon did not receive three months of retroactive relief until nearly a year later. The provider for Huntington, Oregon had to discontinue service and the provider for Milton-Freewater is fighting to stay open.

While the situation in Oregon is especially dire, the dilemma is not isolated to just that state. Even with the relief, providers in almost every state have had to scale back services or reduce the number of ambulance crews. The immediate result is longer response times for an ambulance to arrive at a medical emergency. While the impact of the relief varies by provider, ambulance service providers rely on the temporary relief to help ensure patient access to critical and life saving ambulance services is not jeopardized.

Ambulance Service Providers Being Financially Squeezed

The GAO report identified that ambulance service providers are being reimbursed on average 6% below their costs by Medicare. As I stated earlier, Medicare patients account for about 50% of the volume of an ambulance service provider. Medicaid accounts for an additional 10% of their volume and the uninsured another roughly 10%. Most states reimburse for Medicaid at about half the Medicare rate. So for 70% or more of their services, ambulance service providers are reimbursed at either well below their cost or not reimbursed at all.

In the past, ambulance service providers had been able to shift more of the costs to the 30% of payors who reimburse at or above cost. That is no longer the case. More and more private payors are tying their reimbursement levels to the Medicare rates. This is squeezing ambulance service providers and demonstrates why it is that much more critical that Medicare reimburse ambulance services at least at cost.

A More Permanent Solution to Below Cost Medicare Reimbursement

The Medicare ambulance fee schedule is in need of a one-time infusion of funds to permanently fix the problem of below cost reimbursement. The findings of the May 2007 GAO report should be the basis of that fix. Congressmen Charles Boustany and Richard Neal and Senators Charles Schumer, Pat Roberts and Kent Conrad have introduced the *Medicare Ambulance Access Preservation Act* (H.R. 1005, S. 424) to address this critical need for a permanent solution. The bill would replace the current temporary 2% urban and 3% rural base and mileage increases with a five-year 6% increase as cited in the GAO report. The legislation would also extend for five years the "super rural" bonus payment of 22.6% to the base rate. For providers in "super rural" areas, the 22.6% base rate bump plus the 6% rural increase to the base rate and mileage rate would equal the 17% overall shortfall determined by the GAO. Until Congress can address a more permanent fix, we ask that the current relief be extended.

Potential Offsets to Extensions of Medicare Ambulance Relief

The AAA recognizes the significant difficult fiscal decisions facing policymakers. Our association has taken steps to ensure ambulance service providers are providing quality, efficient care to Medicare beneficiaries. We continue to present our members with robust, ongoing training to enhance care even further and promote best practices. We have developed forums within our association to create the initial stages of a quality improvement and reporting system. Finally, while our industry has one of the lowest payment error rate percentages of any health care provider group, we are helping CMS identify and root out waste and abuse in the Medicare program.

In addition to the above steps that the AAA has undertaken to help reduce costs to Medicare and potentially offset ambulance relief, we acknowledge that systemic reforms must also be considered to ensure the continued viability of the Medicare program and help reduce the deficit. The AAA notes the recent proposal released by the Healthcare Leadership Council as worthy of consideration. While we have not formally endorsed the proposal, it identifies the type of changes that are necessary to help achieve significant savings within Medicare which could be partially used to offset ambulance and other provider relief. Two of the recommendations, the implementation of medical liability reform and the creation of a new "Medicare Exchange" in which provide plans could participate, have particular promise. The AAA has long supported efforts to limit medical liability for emergency medical service providers. The AAA looks forward to working with the Committee as it considers these and other proposals to strengthen the Medicare program.

Conclusion

The current temporary Medicare ambulance relief is doing exactly what is intended. It is allowing a majority of ambulance service providers to maintain current levels of high quality and critically needed emergency and non-emergency ambulance service. The loss of the relief compounded by additional recent cuts in Medicare ambulance reimbursement would change that delicate balance. Providers would have to make difficult decisions that impact patient care and could limit access for everyone in their community to these life saving services. As I stated earlier, some providers have already had to make those very tough decisions and have reduced the number of ambulances serving a community or closed their doors altogether.

Knowing that Congress will extend the temporary relief and address more permanent solutions in the future will allow providers to budget for next year and hopefully many years. Providers will be able to retain or even hire new staff, invest in new equipment and respond to communities outside of their service area that are hit by a natural disaster. This will result in better patient care and ensuring that an ambulance will respond quickly when you call 9-1-1.

About the American Ambulance Association

The American Ambulance Association is the primary national trade association for providers of emergency and non-emergency ambulance services. The AAA is comprised of more than 600 ambulance service operations which account for providing services to over 75% of the U.S. population. AAA members include private, public, fire-based, hospital-based and volunteer ambulance service providers serving urban, suburban and rural areas. The AAA was formed in 1979 in response to the need for improvements in medical transportation and emergency medical services.

Chairman HERGER. Thank you.
Dr. Wah is recognized.

STATEMENT OF ROBERT WAH, MD, CHAIR, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, WASHINGTON, D.C.

Dr. WAH. Thank you, Mr. Chairman, Ranking Member Stark, and Members of the Committee. My name is Robert Wah. I am the chair of the American Medical Association Board of Trustees and a reproductive endocrinologist and obstetrician/gynecologist. I practice and teach at the Walter Reed National Medical Center in Bethesda and the National Institutes of Health.

The AMA, the largest physician organization, and our patients, thanks the chair and Members of the Subcommittee for your leadership in examining the extension of Medicare payment policies for various expiring provisions. I will address four provisions that the subcommittee is examining today.

First is the physician work GPCI, which adjusts payments for geographic differences in the cost of providing services for physician work. In other words, this is a cost-of-living adjustment related to the physician's locality. Adjustments to the GPCIs are required by law to be budget neutral, which means that increasing the GPCI for one set of localities would lead to cuts in all other localities. The AMA has long advocated that the adjustments to the work GPCI should not be constrained by budget neutrality requirements.

The Institute of Medicine, or IOM, is in the process of studying how to improve the accuracy of the data sources and methods used for making geographic adjustments in provider payments. The first of these three IOM reports was released in June. It is critical that changes to the GPCI component be based on the most current, valid, and reliable data.

The AMA believes that once all three reports are released, they should serve as a starting point for Congress to examine geographic adjustments for physician work and practice expenses and ensure that an equitable policy is implemented.

Next, Congress has also intervened on numerous occasions to extend a 5 percent increase in payments for certain Medicare mental health services. These payments have been very important for ensuring access to mental health services by our patients. The AMA's CPT Editorial Board is reviewing descriptions of all psychological services. Following that, the AMA/Specialty Society RVS Update Committee, or RUC, will review the valuation of these services and make related recommendations to CMS. We will share those results with the subcommittee to assist you in your evaluation.

Next, Congress has, with bipartisan support, also intervened to extend the ability of independent laboratories under certain conditions to bill Medicare directly for the technical component of pathology services provided to hospital patients. Without this grandfather provision, Medicare beneficiaries and our patients could experience limited access to surgical services, especially in rural areas, due to the lack of availability of tissue analysis taken out at surgery done by these labs. Bipartisan legislation to make the grandfather provision permanent is currently pending before Congress. We urge congressional consideration of that legislation.

Finally, Congress has intervened to increase Medicare payments for DXA scans for osteoporosis of bones. CMS has asked the AMA RUC to review the valuation of DXA scans as well, which is likely to occur in January 2012. We will share the results of this review

with the committee to guide your further consideration of this issue.

The AMA appreciates the subcommittee's concern about the costs associated with extending expiring provisions. Additional funding that has been allocated for many of these services, however, has been necessary in the absence of a complete overhaul of the Medicare physician payment system. To avoid coming back year after year, Congress needs to undertake comprehensive reform of the Medicare physician payment system, beginning with the immediate and full repeal of the SGR, the granddaddy of the extender problem. Until then, extender payments for these expiring provisions are needed to maintain access to these important services.

New policies for the expiring provisions should be included as part of the new Medicare physician payment system, for which the AMA recommends a three-pronged approach. We have previously shared these recommendations with the subcommittee, and we would be happy to work with you as you try to make them a reality.

The AMA is eager to continue to work with Members of the Subcommittee and Congress to lay the groundwork for Medicare physician payment reform. And we are grateful to Chairman Herger and the subcommittee for calling this important hearing today.

Thank you. And I am happy to answer any questions.

[The prepared statement of Dr. Wah follows:]

****THIS TESTIMONY IS EMBARGOED UNTIL 2:00 PM ON WEDNESDAY, SEPTEMBER 21, 2011****

STATEMENT

of the

American Medical Association

before the

House Ways and Means Committee
Subcommittee on Health

RE: Expiring Medicare Provider Payment Policies

Presented by Robert M. Wah, MD

September 21, 2011

Division of Legislative Counsel
202 789-7426

Statement of the

American Medical Association

before the

House Ways and Means Committee
Subcommittee on Health

RE: Expiring Medicare Provider Payment Policies

Presented by Robert M. Wah, MD

September 21, 2011

The American Medical Association (AMA) is pleased to have the opportunity to provide the House Ways and Means Subcommittee on Health with our views on expiring Medicare payment policies concerning: (i) the work geographic practice cost index (GPCI); (ii) the five percent mental health add-on; (iii) direct billing by independent laboratories for the technical component of certain pathology services; and (iv) certain dual-energy x-ray absorptiometry services (DXA scans).

The AMA recognizes that there are a number of Medicare provider payment policies that expire on or before December 31, 2011, and that many of these policies have been extended multiple times over a number of years. We applaud Chairman Herger for his leadership in examining whether these policies are still needed and appropriate. It is critical to continually examine Medicare payment policies and ensure that Medicare payments reflect increases in the cost of practicing medicine and maintain access for Medicare beneficiaries to critical medical services.

Some of the expiring provisions the Subcommittee will be examining include:

- **Physician Work GPCI**

  Under current law, the Centers for Medicare and Medicaid Services (CMS) is required to establish Geographic Practice Cost Indices (GPCIs) to adjust the Medicare payment rate for physicians' services. The GPCIs are intended to adjust payments for geographic differences in the cost of providing services, including for physician work (or cost-of-living adjustments), practice expenses, and medical liability insurance. GCPIs are calculated for each of 89 localities across the Unites States. Adjustments to the GPCIs are required by law to be made on a budget neutral basis, which means that increasing the GPCI for one set of localities would lead to cuts in all other localities. This budget neutrality provision has created friction among and within states and regions, as well as between rural and urban areas. **The AMA has long advocated that any adjustments to the work GPCI should not be budget-neutral.**

On this basis, the AMA has supported numerous Congressional interventions to extend the work GPCI floor of 1.0, which applies to any locality for which the index is less than 1.0. For example, the Patient Protection and Affordable Care Act (ACA) extended the floor of 1.00 on the work GPCI through 2010, and the Medicare and Medicaid Extenders Act of 2010 (MMEA) extended this work GPCI floor through 2011. The work GPCI provision has been funded with new money and has not been implemented on a budget-neutral basis.

At the request of the Secretary of the Department of Health and Human Services, the Institute of Medicine (IOM) is in the process of studying and issuing three reports on how to improve the accuracy of the data sources and methods used for making the geographic adjustments in payments to providers. The AMA has met with the IOM and provided extensive information for the IOM to examine in developing its reports. In June of this year, the IOM issued a report, which recommends an integrated approach that includes:

- moving to a single source of wage and benefits data;
- changing to one set of payment areas and labor markets; and
- expanding the range of occupations included in the index calculations.

The IOM also recommends developing a new source of data on the cost of office rent and applying the hospital wage index for facilities other than acute-care hospitals.

The June report was the first of three to be issued by the IOM. A supplemental report that discusses physician payment issues further will be issued, along with a final report that is expected to be released in 2012.

The AMA believes that once these reports are complete, they should be a starting point for Congress in examining geographic payment adjustments for physician work and practice expenses. The Subcommittee should also examine the impact of the IOM recommendations on physicians and other Medicare providers. For example, the IOM recommends changing to one set of payment areas and labor markets. Specifically, the IOM recommends that Medicare should employ the metropolitan statistical areas (MSAs) developed by the Office of Management and Budget for hospitals and health professionals, including physicians. Currently, there are 441 markets to determine hospital payments and a different set of 89 markets for physicians and health practitioner adjustments. Moving to a single set of markets would create significant changes for many localities, with varying impacts, which must be closely examined.

Upon completion of the IOM reports, the AMA looks forward to working with the Subcommittee and Congress to develop accurate and equitable geographic payment adjustment policies. It is critical, in developing new GPCI payment policies, that the most current, valid, and reliable data are collected and applied in calculating accurate GPCIs and in determining geographic payment areas for use in the Medicare

physician payment system, with data collected from rural practice sites for this purpose.

- **Mental Health Add-On Payment**

  Congress has intervened on numerous occasions to extend a five percent increase in payments for certain Medicare mental health services through December 31, 2011, most recently under the Medicare and Medicaid Extenders Act of 2010. These add-on payments have been important for ensuring access to mental health services. The AMA CPT Editorial Panel is reviewing the descriptions of all psychological services, and upon completion of this review the AMA/Specialty Society RVS Update Committee (RUC) will review the valuation of these services and make related recommendations to CMS.

- **Direct Billing for Technical Component of Pathology Services**

  Congress, with bipartisan support, has also intervened to extend the ability of independent laboratories, under certain conditions, to bill Medicare directly for the technical component (TC) of anatomic pathology services provided to hospital patients through December 31, 2011. The TC of anatomic pathology services are physician services under Part B and include the preparation of tissue samples for pathologist examination and diagnosis. Congress has consistently provided relief in the form of a "grandfather" provision to limit implementation of a regulation that would otherwise eliminate Medicare payments to independent laboratories for these TC services. The "grandfather" applies to hospitals that were using an independent laboratory for these services as of July 22, 1999. A covered hospital can utilize any independent laboratory for these services, which allows for competition among laboratories for delivery of services, and allows hospitals to choose the laboratory that best meets their needs. Without this grandfather provision, there would be significant hardship for independent laboratories and hospitals, along with substantial disruption for patients. Hospitals would have to absorb new costs without a payment increase. New complex billing systems and administrative operations would be required for both the hospital and laboratory. For Medicare beneficiaries, this could result in limited access to surgical services in their hometowns. Smaller hospitals and rural communities would be especially hard hit. Bipartisan legislation to make the grandfather provision permanent is currently pending before Congress.

- **Dual-Energy X-Ray Absorptiometry Services**

  Medicare payment for bone density screenings for osteoporosis were reduced by CMS after the agency discovered a clerical error in direct practice costs for DXA scans that resulted in increased payments for these services. The ACA increased payments for certain DXA Scan services to 70 percent of the 2006 Medicare payment level for 2010-2011. After 2011, the payment rate for DXA scans will be reduced by 50 percent. Currently, legislation pending before Congress would extend payment for DXA scans at the current payment rate through 2013. CMS has asked the AMA RUC

to review the valuation of DXA scans, and the RUC likely will undertake this review at its January 2012 meeting.

The AMA understands the Subcommittee's concern about the costs associated with continually extending modified payment policies for these and other expiring provisions. The AMA believes, however, that the additional funding that has been allocated for many of these services has been necessary in the absence of a complete overhaul of the Medicare physician payment system. Due to the flawed sustainable growth rate (SGR), there has been a massive shortfall in Medicare funding for physicians' services. Over the last decade, temporary patches have not kept up with the growth in physician practice costs and real inflation-adjusted Medicare payment rates have been cut 16 percent. Physicians also face a 29.5 percent across-the-board payment cut scheduled for January 1, 2012. Until Congress repeals the current SGR and replaces it with a new Medicare payment system that fairly pays for physicians' services and keeps up with increases in medical practice costs, "extender payments" for these expiring provisions are needed to maintain critical access to these services for Medicare beneficiaries.

Medicare physician payment updates since 2001 have not kept up with the cost of running a medical practice, leaving a 20 percent gap between payment rates and practice expenses. Further drastic cuts pose a very real risk to physicians' ability to retain staff, care for Medicare patients and make the investments needed to modernize their practices and participate in care delivery models intended to improve quality while reducing costs in the Medicare system.

New policies for these expiring provisions should be developed as part of a new Medicare physician payment system. The AMA has recommended a three-pronged approach to reforming the Medicare physician payment system:

(1) Repeal the SGR;
(2) Implement a five-year period of stable, positive Medicare physician payments; and
(3) Transition to an array of new payment models designed to enhance care coordination, quality, appropriateness and costs.

During this period of stable, positive Medicare physician payments, new models would be tested to lay the pathway for a new payment system. These new models should also test new proposals and payment policies that would result in accurate and equitable Medicare payment for the services of these expiring provisions. The AMA is eager to continue to work with members of the Subcommittee and Congress to lay the ground work for Medicare physician payment reform, and we are grateful to Chairman Herger and the Subcommittee for calling this important hearing today.

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Chairman HERGER. Thank you.
Mr. Moore, you are recognized for 5 minutes.

STATEMENT OF JUSTIN MOORE, VICE PRESIDENT OF GOVERNMENT AFFAIRS, AMERICAN PHYSICAL THERAPY ASSOCIATION, ALEXANDRIA, VA

Mr. MOORE. Chairman Herger, Ranking Member Stark, and members of the Health Subcommittee, on behalf of the American Fiscal Therapy Association and its 82,000 members, thank you for the opportunity to provide testimony on expiring Medicare provider payment policies.

I am Justin Moore, a licensed physical therapist and currently the Vice President of Government Affairs at APTA. Several of the expiring payment policies under Medicare impact physical therapists, including the sustainable growth rate, rural payment policies, and the Medicare cap on outpatient physical therapy, occupational therapy, and speech/language pathology. We will focus today's testimony on the therapy caps by providing the background of this policy, its impact on patient and providers, and a potential solution to this issue.

In addition to our membership and the patients we serve, APTA is also working in coordination with the Therapy Cap Coalition, an advocacy community of over 50 patient and professional organizations whose common objective is to permanently repeal the caps. This coalition appreciates the current leadership of Representative Gerlach and Javier Becerra to repeal the therapy caps.

The therapy caps are primarily a beneficiary issue and secondly a payment policy issue for therapists. As part of the Balanced Budget Act, Congress authorized a $1,500 cap on outpatient therapy services under Medicare Part B. From 1999 to 2006, Congress passed three moratoriums on the therapy caps. In 2006, Congress reformed the moratorium policy by authorizing an exceptions process to the therapy cap that initially decreased its cost. Congress has extended this exceptions process five times. And the current exceptions process is valid through the end of this year.

If Congress allows the exceptions process to expire, beneficiaries will not receive the services that are medically necessary unless they seek treatment from a hospital outpatient department or pay out of pocket for their care. Without the exceptions, it has been estimated that 15 percent of the beneficiaries that access therapy services, or 640,000 Medicare beneficiaries, would reach that cap and have their access to therapy services reduced or eliminated.

In particular, the therapy cap has a disproportionate impact on older, more chronically ill beneficiaries and those from underserved areas. Without the exceptions process, these patients would likely regress in their health status and create additional Medicare expenditures to address their health care needs.

Congress has long known that allowing the therapy caps to go into effect would have a profound impact on patient care. The pattern of yearly extensions without an exit plan is not in the best interest of patients, physical therapists, or the Medicare program. APTA believes the therapy cap exceptions process must be extended in 2011 but further recommends that reforms to the payment system and the benefit are needed for the long-term fiscal health of the program.

The original legislative intent of BBA authorized the therapy caps but called for an alternative payment methodology to eventu-

ally replace those caps. APTA proposes to Congress that we extend a refined exceptions process for 2012, 2013, and 2014, and instruct CMS to develop a per-visit payment system for outpatient therapy services that controls the growth of therapy utilization, with implementation by January 1, 2015.

APTA has begun work on a reform patient system for outpatient physical therapy services that we believe would strike the balance between ensuring access to services while improving payment accuracy for therapist services under Medicare.

APTA is developing a reform payment system that would transition the current system to a per-visit system based on the severity of the patient and the intensity of the therapist's clinical work and judgment. The therapy evaluation would provide a prediction of the episode of care and the estimated rehab potential for the patient. APTA is working with stakeholders in the therapy and rehabilitation community to refine this system.

We believe the system has potential long-term cost savings through increased compliance with other areas of payment policy under the Medicare therapy benefit, advancing efforts toward quality reporting and the adoption of health information technology, standardization of practice patterns through assessment tools and registries, and a diminished potential for fraud and abuse.

APTA stands ready to work with the committee to reform the payment system for therapy services and refine the benefit to ensure the integrity of these services. We commend the committee for this hearing on expiring Medicare policies and encourage an extension of the therapy cap exceptions process, a movement to a reformed payment statement, and refinements to the therapy benefit.

Thank you.

[The prepared statement of Mr. Moore follows:]

OFFICIAL STATEMENT

1111 North Fairfax Street
Alexandria, VA 22314-1488
703 684 2782
703 684 7343 fax
www.apta.org

Expiring Medicare Provider Payment Policies

United States House of Representatives
Committee on Ways and Means
Subcommittee on Health

September 21, 2011

Justin Moore, PT, DPT
Vice President, Government and Payment Advocacy
American Physical Therapy Association

Chairman Herger, Ranking Member Stark, and Members of the Health Subcommittee of the House Committee on Ways and Means:

On behalf of the American Physical Therapy Association (APTA) and its 82,000 members, thank you for the opportunity to provide testimony on Medicare payment policies that expire at the end of the 2011 calendar year and our perspective on a particular policy that should be extended, the exceptions process to the financial limitations on outpatient physical therapy, occupational therapy, and speech-language pathology services. These arbitrary therapy caps on rehabilitation services that beneficiaries can receive in a year adversely impact seniors and individuals with disabilities, especially those most in need of these critical services. The therapy caps are primarily a beneficiary issue that expire at the end of the year and secondarily a payment policy issue for the qualified providers of these services; physical therapists, occupational therapists and speech-language pathologists.

The therapy cap impacts a wide spectrum of patients and providers. This has resulted in an advocacy community of almost 50 patient and professional organizations whose common objective is to repeal the therapy caps once and for all. Many of these providers of therapy services or patients that receive them are also impacted by other expiring payment policies under the Medicare physician fee schedule that threaten the viability of outpatient rehabilitation for Medicare beneficiaries, including the sustainable growth rate and rural payment updates. This confluent of patient issues and provider payment policies threatens the availability and accessibility of rehabilitation services for the Medicare population.

Physical therapy services are cost-effective outpatient services under the Medicare Part B program that assist beneficiaries to restore function and independence. In 2008, therapy services served 4.5 million beneficiaries or 10.5% of the 42.7 million Part B beneficiaries. These services account for $4.76 billion in Medicare outpatient therapy or 2.6% of $183.3 billion in Part B expenditures and 1% of all Medicare Expenditures (Part A, Part B, and Part D combined). The average patient receives $884 in services over 11.2 treatment days.

Physical therapists provide critical health care services to assist beneficiaries under Medicare Part B to remain in their homes, communities and society at their highest potential functional level. An arbitrary cap on these services would shift costs as beneficiaries delay or decline needed care. A report issued in June 2010 by CMS's contractor, showed that in 2008, 15.3% of patients exceeded the physical therapy/speech language pathology cap. The exceptions process maintained access to physical therapy services for just over 640,000 individuals at a cost of $848 million dollars.

Once exceeded, if there is no exceptions process in place beneficiaries will not receive services that are medically necessary unless they seek treatment from hospital outpatient departments or pay out of pocket for their care. As a result, the cap can be expected to have a significant detrimental effect on beneficiaries needing rehabilitation services. In particular, the therapy cap has a disproportionate impact on older, more chronically ill beneficiaries from under-served areas, such as rural and urban population centers. Without this exceptions process, these patients

would have regressed in their health status and likely cost the Medicare program additional expenditures with admissions to facilities or visits to additional providers to address their health care needs.

Moving forward with cost-effective, sound policies that ensure access to services, eliminate inappropriate or fraudulent services, and guarantee quality care delivered by health care professionals qualified to deliver these services is a goal we share with this Committee. To meet this goal we have worked with CMS and members of Congress, including the bipartisan leadership on this Committee from Representative Gerlach and Becerra, to repeal the caps and replace them with an equitable alternative payment methodology for therapy services. APTA urges Congress to take timely action to pass legislation to repeal the therapy caps or to extend the exceptions process as an alternative payment policy for outpatient therapy services is developed.

Background of the Outpatient Therapy Cap

As part of the Balanced Budget Act (BBA) of 1997, Congress authorized a $1500 therapy cap on outpatient therapy services furnished in private practice settings, physician offices, skilled nursing facilities (Part B), comprehensive outpatient rehabilitation facilities, and rehabilitation agencies. Prior to the enactment of this legislation, the only setting that had been subject to an annual limitation on therapy services was the private practice physical therapist office. Congress exempted outpatient hospital settings from the therapy cap. Due to a quirk in statutory language, it was determined that two caps would exist, one on physical therapy and speech-language pathology combined and one on occupational therapy services. The therapy caps authorized in the Balanced Budget Act were designed to be a temporary measure until the Centers for Medicare and Medicaid Services (CMS) provided an alternative payment methodology for therapy services for Congress' consideration. The authorizing language from BBA also provided for inflationary growth beginning in 2002 for the financial limit. Today the therapy cap is $1870 per beneficiary per year for physical therapy and speech-language language and $1870 per beneficiary per year for occupational therapy with a clinically based exceptions process. This exceptions process to the therapy cap will expire on December 31, 2011.

The therapy caps originally went into effect on January 1, 1999, but were not enforced due to limitations in implementing them at the agency and local contractor level. On November 19, 1999, Congress passed the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, which placed a two-year moratorium on the $1,500 cap for 2000 and 2001. Congress passed legislation again in 2000 as part of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) to extend the moratorium on the therapy caps through 2002. In 2003, CMS delayed enforcement of the therapy cap from January 1, 2003, through September 1, 2003. The therapy cap was in place from September 1, 2003 until Congress passed the Medicare Modernization Act that extended the moratorium on the therapy cap from passage on December 8, 2003, through December 31, 2005. In the first six years of the therapy cap, Congress passed moratoriums on this policy three times and the caps were in effect for just under 100 days.

The therapy caps again went into effect temporarily on January 1, 2006, but were quickly addressed in the Deficit Reduction Act passed by Congress on February 1, 2006 by extending the exceptions process to the therapy cap. Originally, CMS implemented a two-tier approach of an automatic exceptions process for certain diagnoses likely to exceed the therapy cap and a manual process for clinicians to provide justification of medically necessary care above the arbitrary financial limitation of the therapy cap. This was modified and now allows for the use of a code based modifier to signify that therapy services above the financial limit are medically necessary and appropriate.

Congress has supported this reform to the therapy cap by providing an extension to the exceptions process five times since 2005, through the passage of the Tax Relief and Health Care Act of 2006, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act, Medicare Improvement for Patients and Providers (MIPPA) (PL 110-275), the Patient Protection and Affordable Care Act (PL 111-148), and the Medicare and Medicaid Extenders Act of 2010. The current extension of the therapy cap exceptions process expires on December 31, 2011.

The Impact:

For the Medicare beneficiaries who exceed the cap the result is detrimental and potentially devastating. The therapy cap has a detrimental impact due to several factors. First, the therapy cap is a per year per beneficiary limit. For a patient with multiple chronic conditions and it has been estimated that almost 70% of Medicare beneficiaries have more than one chronic condition, physical therapy is critical to preserving function and regaining function following an impairment. To exhaust the cap for physical therapy to treat a knee impairment only to have no therapy benefit left to treat another condition, such as a cardiac condition that results in deconditioning is short-sighted and limits gain invested in the first physical therapy treatment plan.

Second, the combined cap of physical therapy and speech-language pathology is problematic as these are distinct clinical services that occur at different times in the continuum of care and address related but separate areas of impairment. A patient with a stroke might receive extensive physical therapy to regain mobility but then see the cap limit their ability to obtain services to improve swallowing or the ability to communicate. This example of giving the patient a choice between walking and talking is an oft-cited example of the complicating factors and poor policy of the therapy cap.

And finally, services under Medicare are required to be medically necessary and providers, such as physical therapists, must meet the required regulations to demonstrate this requirement. The therapy cap places an arbitrary stopping point to therapy regardless of the necessity of the services. A patient has demonstrated need for care and we have a policy that over-rides that need. Beginning physical therapy care with the knowledge that you will be limited in your abilities to meet the patient's need due to the therapy cap places clinicians in a difficult and challenging position.

Congress has long known that allowing the therapy caps to go into effect would have a profound impact on patient care. The pattern of yearly extensions without an exit plan is not in the best interest of patients, physical therapists or the Medicare program. APTA believes the therapy cap exceptions process must be extended in 2011 and furthermore believes that reform to the payment system and benefit is needed for the long-term fiscal health of the program and to meet growing needs for cost-effective rehabilitation services under Medicare.

The Solution:

APTA believes a strong Medicare Part B program is essential to provide cost-effective, accessible and high quality health care to our nation's seniors and individuals with disabilities. The policies established under the Medicare program dramatically impact payment policies established by private payers, Medicaid, workers compensation, and others payers. The opportunity to address these fundamental policy problems under Medicare Part B is vital to move toward a sustainable delivery system that is supported by sound payment policies.

The original legislative language authorizing the therapy caps called for an alternative payment methodology to replace the caps. Without significant development in this alternative, APTA proposes that Congress extend a limited exceptions process for 2012, 2013, and 2014 and instruct the CMS to develop a per visit payment system for outpatient therapy services that controls the growth of therapy utilization for implementation by January 1, 2015. APTA has begun work on a reformed payment system for outpatient physical therapy services that we believe will strike the balance of ensuring access to services while improving payment accuracy for therapy services under Medicare Part B.

APTA would support efforts by Congress to refine the exceptions process. We encourage Congress and this Committee to work with CMS to identify ways to implement an exceptions process that ensures that patients needing services beyond the therapy cap receive those services, minimizes the administrative burden on CMS and providers, while reducing the cost of extending the therapy cap exceptions process. Limiting the exceptions process is only meant to provide temporary reductions in spending while providing a bridge to the long-term solution. APTA is working with stakeholders in the community on legislative language to meet this aim.

In addition, Congress should include language instructing CMS to develop and adopt a reformed payment system for therapy services. APTA is working on a per visit payment system that we believe will enhance the accuracy of payment for physical therapy services and prevent inappropriate billing of therapy services by non-qualified individuals. This will involve the development of a new coding structure and values for physical therapy services through the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel and AMA's Specialty Society Relative Value Scale Update Committee (RUC). This would allow for the reformed payment system to be presented to CMS for consideration in time for publication in the CY 2015 Medicare Physician Fee Schedule Rule and for implementation on January 1, 2015.

The reformed payment system APTA is developing would be per session codes based on the severity of the patient and the intensity of therapist clinical judgment and work involved in the provision of the therapy service. The physical therapy evaluation would be tiered to provide a prediction of the episode and estimated rehabilitation potential through assessment of patient severity and the intensity of services needed to meet the patient's rehabilitation goals. In addition to the evaluation process, the per session payment system would classify each patient encounter by associating it to one of three levels of patient severity that could be documented and reported on a claim form. These could include: low clinical presentation/severity; moderate clinical presentation/severity; and high clinical presentation/severity. These encounters would also be associated with an intervention level that would be characterized as low, moderate, and high. Together the evaluation and then per-visit examination and intervention system would provide a payment system that accurately reflects the professional clinical judgment of the therapist and provides the payers of these services with more meaningful ways to assess the appropriateness of these services.

We believe, and there is evidence to support, that the severity of the patient is impacted by the medical condition of the patient, the physical impairments resulting from these conditions(s), the patient's ability to function, and their ability to participate in activities of daily living. These factors, taken together, underlie the provider's judgment about the "severity" level (minimal, moderate, and significant) of the patient's condition. For example, two individuals with a diagnosis of stroke could differ significantly in severity level based on the number and impact of resulting impairments, the inability to perform functional tasks and activities, and their ability to participate in activities related to their societal roles. It is incumbent upon the therapist to make a clinical judgment based on their significant expertise regarding the impact of these factors on the patient and the plan of care. The intervention level involves a series of judgments that the therapists must make regarding the particular combination of interventions to implement, how much of each technique to provide during each patient encounter, and the optimal duration of the care.

APTA believes the use of per-session payment could result in more appropriate valuation of therapy services and permit clinicians more flexibility in determining intervention approaches to reach the patient's rehabilitation goals. Per-session payments that reflect average per-session costs based upon the severity of the patient's condition and complexity of the services required, would eliminate overpayment for individual services provided while leaving the therapist in control of treatment decisions. These factors could lead to more predictable and reduced therapy expenditures.

This approach would ensure compliance with other areas of payment policy under the Medicare rehabilitation benefit, such as delivering care that is medically necessary and driven by the development of an appropriate functional goal-based plan of care. We also believe this will be congruent with and advance efforts in quality reporting, health information technology and the standardization of practice patterns through assessment tools and registries. Although this system needs refinements and further development to ensure appropriate safeguards, APTA believes it is far superior to the current time-based procedural system that value volume over

outcomes. This reformed payment system has the potential to not only improve payment accuracy and better reflect quality care, but provide long-term cost savings through greater efficiency and accuracy in billing. This new payment policy couples with needed reforms to reduce fraud and abuse, such as the elimination of the in-office ancillary services exception to the federal self-referral ban (also known as Stark law) that has recently been studied by the Medicare Payment Advisory Commission (MedPAC) would be an example of potential reforms to the therapy benefit to reduce unwarranted spending.

Providing Savings under Medicare to Pay for the Cost of These Policy Proposals

APTA would highlight the following three cost saving proposals for consideration to provide savings to pay for the cost of these policy proposals to address the therapy cap and payment reform under Medicare Part B:

Strengthen Medicare Program Integrity Efforts
Legislative proposals to intensify program integrity efforts include penalizing providers who do not update their enrollment records, validating physician orders prior to payment for certain high-risk services, and requiring prepayment review for all power wheelchairs. These program integrity proposals were included in the President's FY 2012 Budget and have also been identified by members of the House Majority for debt ceiling/deficit reduction options. The Congressional Budget Office estimates the potential savings of this proposal at $700 million over 10 years.

Recover Erroneous Payments Made to Insurers Participating in Medicare Advantage
Under current law, CMS is required to risk adjust payments to Medicare Advantage (MA) plans to reflect variation in health risk, and thus cost, of different beneficiaries. In 2008, CMS announced a pilot program to audit a sample of plans' records to validate the accuracy of the adjusted payments. Under this pilot program, CMS evaluates the medical records of beneficiaries (validation audits). The President's FY 2011 and FY 2012 budgets included a policy that would require CMS to extrapolate the error rate found in the risk adjustment validation audits to the entire Medicare Advantage plan payment for a given year. This policy option would ensure that Medicare is accurately paying Medicare Advantage plans by identifying – and correcting – both overpayments and underpayments. The Congressional Budget Office estimates the cost savings of this proposal to be $2.6 billion over 10 years.

Medicare Improvement Fund
The Medicare Improvement Fund (MIF) has been used in recent years as a venue to "store" excess Medicare savings so that they could be used in the future to pay for needed Medicare policy (e.g., SGR patches, Medicare extenders, etc). Under current law, the Recovery Act created penalties for Medicare providers that have failed to adopt and meaningfully use electronic health records by 2015. In 2019 and beyond, those penalties are put into the MIF. This proposal would remove them from the MIF to make them available for deficit reduction or to offset other spending in the package. The Congressional Budget Office estimate of cost savings from this proposal is $900 million over 10 years.

In closing, APTA stands ready to work with the Committee to reform both the current therapy benefit under Medicare Part B, to ensure that therapy services are only provided to beneficiaries by qualified providers of these services, and to reform the payment system to meet the original language of the Balanced Budget Act that authorized this temporary therapy cap. We believe a reformed payment system and cleaning up of the benefit to ensure the integrity of the services are the only way to ensure beneficiary access and to have an adequate payment system to sustain a qualified provider community to serve these beneficiaries in a high-quality, cost-effective fashion. We commend the Committee for this hearing of expiring Medicare policies and encourage an extension of the therapy cap exceptions process.

Chairman HERGER. Thank you, Mr. Moore.
Mr. Steinwald is recognized for 5 minutes.

STATEMENT OF BRUCE STEINWALD, PRESIDENT, STEINWALD CONSULTING, WASHINGTON, D.C.

Mr. STEINWALD. Thank you, Chairman Herger.

Mr. Stark, nice to see you again.

Members, thank you for having me here today.

I might as well get it right on table; my role is to be the skunk at the picnic. But I welcome the opportunity, because I am very concerned about Medicare's financial situation and the unsustainable trend line that it is on.

I became a health economist in the1960s, about the time that Medicare was enacted, and now I am a Medicare beneficiary myself.

It has been well established by the Congressional Budget Office and others how the Medicare spending problem is not only a Medicare problem, but it is a deficit problem and a national debt problem. And for those reasons, I think that any discussion of health policy and Medicare issues, including the issue before the committee today, ought to have affordability as one of the principal criterions that you apply when you consider whether you should extend some of these expiring provisions.

There are three reasons I think that Congress should be very skeptical about these extensions. One, Mr. Chairman, you mentioned yourself, is they are costly in their own right. They are deceptively costly. They don't look like they are all that expensive, taken one at a time, but if you looked at them, as you do, in a package over a 10-year budget window, they would be on the order of $25 billion. And even that is an underestimate considering that many of these provisions have a lifetime of more than 10 years.

There are two other reasons, though, that I think are equally important. One is, when you make exceptions, you undermine the integrity of Medicare's payment systems. Congress worked very hard since 1983 when it put in the inpatient prospective payment system to move away from inflationary cost reimbursement and in the direction of a reimbursement system that allows providers to understand what they will be paid for a given service and therefore manage their cost to that payment. When you make exceptions, you undermine that incentive. You encourage providers to seek exceptions rather than to seek efficiencies. And, of course, you create a constituency for the continuation of the exceptions and for other providers to say, where is my exception, if they are not so blessed.

A third reason is, we all know that the incentives of fee-for-service payment lead to more volume and more complex services. And that is a major contributor to spending. Again, once you make exceptions, it tends to undermine some of the limited checks and balances that the Medicare program has to make sure that the services that it pays for are reasonable and necessary for patient care. Exceptions tend to undermine that.

I included a number of examples in my written statement. Let me touch on one or two of them. I serve on the Institute of Medicine committee that Dr. Wah mentioned in his statement. That committee is looking at Medicare's geographic payment adjustments for hospital and physician services. Fully 37 percent of hospitals are currently paid for under some kind of exception to the basic payment formula, 37 percent. That includes the 508 excep-

tions, but it is not limited to that. There are other kinds of exceptions as well.

It needn't be that way. There are ways to improve the payment formulas for hospitals and physicians and other Medicare providers. But, once again, it dilutes some of the energy to finding those payments if you are expending your energy finding exceptions and getting them extended as opposed to improving the payment system.

Many of the rural provisions seem to—they prop up rural payments, but they also create exceptions that have the same problems that I have already mentioned. I especially don't like floors in either the inpatient or the physician payment systems, floors on the geographic adjustments. It perpetuates this idea of a Lake Wobegone world in which no one can be below average. And it has the effect of messing up payments for all providers, not just a limited few.

In order to not take any more time, let me just say, I am sorry to play this role, but I do think that Congress should be very, very cautious about extending these provisions. It should set a very high bar. There should be compelling evidence of a beneficiary need for any of these extensions. And Congress should think about whether we want the exception to be extended or whether or not we want an improvement in the payment formula.

That ends my oral statement. I am happy to answer any questions.

[The prepared statement of Mr. Steinwald follows:]

THIS TESTIMONY IS EMBARGOED UNTIL 2:00 PM ON WEDNESDAY SEPTEMBER 21, 2011

Testimony

Before the Subcommittee on Health,

Committee on Ways and Means,

House of Representatives

CONGRESS SHOULD NOT EXTEND EXPIRING EXCEPTIONS TO MEDICARE PAYMENT POLICIES WITHOUT COMPELLING EVIDENCE BASED ON BENEFICIARY NEED

Statement of A. Bruce Steinwald

President, Bruce Steinwald Consulting

September 21, 2011

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to participate in your hearing on expiring Medicare provider payment policies. I am Bruce Steinwald, head of a small consulting practice consisting of myself and a home office where I prepared this statement. I also serve as a member of the Institute of Medicine's (IOM) Committee on Medicare's Geographic Payment Adjustments and as co-chair of the National Quality Forum's (NQF) Steering Committee on Health Care Resource Measures. Until early last year I was with the Government Accountability Office (GAO) Health Care Team. I directed many health care -related studies and testified before this committee and other congressional committees on Medicare payment and health care spending issues.

I have held several positions both inside and outside of government for decades, including serving as Deputy Director of ProPAC, one of the Medicare Payment Advisory Commission's (MedPAC) forerunners, in the 1980s. I became a health economist about the same time that Medicare was enacted in the mid-1960s and now I am a Medicare beneficiary myself. I feel very strongly about getting Medicare on a sustainable path, not only for my own benefit but also for the sake of future beneficiaries and current and future taxpayers.

My remarks today consist of three principal parts: first, a brief statement about the severe financial situation that the Medicare program faces as backdrop to any discussion of Medicare payment policy; second, reasons why Congress should be very cautious about extending exceptions to Medicare's payment rules; and third, specific examples pertaining to selected Medicare payment policies. My remarks are confined to fee-for-service payments under the traditional Medicare program and exclude discussion of Medicare's Sustainable Growth Rate policy pertaining to the physician fee schedule.

Affordability Should Be an Important Factor in Medicare Payment Policy. As you well know, Medicare has a huge spending problem. Because the links between Medicare spending and our deficit and national debt problems have

been well established by CBO and others, I will not go into the details here.[i] However, I believe that the unsustainability of current levels of Medicare spending needs to be kept in mind in all discussions of Medicare payment policy, including the issue before the Subcommittee today. For years we have used criteria such as quality of care, beneficiary access to services, provider equity, and, more recently, value of services to guide Medicare payment policy discussions. In light of Medicare's spending problem, I believe we should include another criterion in all such discussions – affordability.

Congress Should Be Reluctant to Extend Exceptions to Medicare's Payment Rules. Congress should be very skeptical about extending exceptions to Medicare's payment policies for three reasons:

First, extenders, as they are called, are costly. Individually, they may not appear expensive given Medicare's overall level of spending, but when added up, as indicated in the Chairman's hearing advisory, their combined level of spending totals more than $2.5 billion per year. The Chairman also pointed out that Congress has frequently changed the expiration date without much analysis or debate. Consequently, the actual budgetary cost of the extenders is far more than their one-, two-, or three-year lifetimes. If you look at the extenders as a group and consider them as permanent changes rather than temporary, and evaluate their budgetary impact as you would potential new legislation, their impact in a ten-year budget window would be $25 billion, not $2.5 billion. Even that is an underestimate considering that many of these policies have a lifetime more than ten years.

Second, exceptions and their extensions tend to undermine the integrity of Medicare's payment systems. Since the creation in 1983 of the hospital Inpatient Prospective Payment System (IPPS), Congress has worked very hard to replace inflationary cost reimbursement with formula-based payments that vary according to patient condition and provider costs of doing business. These formulas permit providers to know in advance what they will get paid for a particular service so that they can manage their costs to prosper, or at least survive, within Medicare's contribution to their bottom lines. Exceptions tend to undermine providers' incentives to be as efficient as possible. Further, if one

provider or group of providers obtains an exception, other providers quite naturally say, "Where's my exception?" At the same time, those who obtain exceptions become dependent on them, leading to the ongoing demand to extend them indefinitely. I believe Congress should encourage Medicare providers to improve their efficiency rather than seek exceptions to Medicare's payment rules.[ii]

Third, exceptions tend to exacerbate the incentives in Medicare's fee-for-service payment systems to drive volume and complexity of services upward. I have been impressed (or depressed) over the years with the strength and dependability of these incentives to increase Medicare spending per beneficiary.[iii] Medicare's payment formulas have a limited number of checks and balances to ensure that the services it pays for are "reasonable and necessary" for patient care. It makes little sense to further weaken these restraints on spending by fostering exceptions to Medicare's payment rules.

When is an Exception or Extension Justified? Given these reasons for restraint, it is natural to ask when, if ever, an exception or its extension is warranted. I believe that two conditions should be met. First, there should be compelling evidence that a substantial beneficiary interest is at stake. By "compelling," I mean that the evidence of should be clear that providers cannot furnish adequate access or quality of services to Medicare beneficiaries without an exception or its extension. By "substantial," I mean that the beneficiary need should be widespread and not just isolated, atypical cases. Given Medicare's financial situation, I believe the bar should be set very high for providers to demonstrate compelling evidence of a substantial beneficiary need in extending an exception to Medicare's payment policies.

Second, if a demonstrable problem exists, can it be rectified through an improvement in the payment formula rather than through an exception? The accuracy of many of Medicare's payment formulas can be improved with better methods and data. It is far more preferable to update these formulas periodically, making them more accurate for providers as a whole, than to grant some providers exceptions to an imperfect payment system. I will say more

about the need to improve payment systems in my discussion of the hospital wage index below.

Medicare Needs Savings, Not Offsets. Before going on to examples, let me say a word about offsets. Given the choice, I would prefer that the Congress find offsetting savings if it decides to extend a payment policy exception, compared to an increase in spending. But Medicare needs savings more than it needs offsets. The Congressional Budget Office, among others, annually publishes a report detailing potential options to reduce Medicare spending and the consequences of failing to do so.[iv] If there are ways to achieve savings, by all means take them and reduce Medicare's contribution to the deficit. The availability of offsets, however, should not reduce your skepticism about the continued need for these costly extenders.

Several Examples Illustrate the Difficulties Created by Payment Exceptions and Extensions. Certain of the payment exceptions and extenders due to expire are illustrative of the dilemma they create for policy makers seeking to rein in excessive Medicare spending. I will cover a few of these policies as examples, but it should be understood that the difficulties they create pertain to all such policies, not just those mentioned below.

Improving the accuracy of the hospital payment formula could eliminate the need for Section 508 and other exceptions to the Hospital Wage Index. The IOM committee to examine the geographic payment adjustments in Medicare's fee-for-service payment formulas took a fresh look at the Hospital Wage Index adjustment, which was instituted in 1983 when the hospital PPS was created. Since then, many hospitals have been reclassified for payment purposes and many other types of exceptions have been granted, including the Section 508 provisions due to expire October 1, 2011. At present, fully 37 percent of hospitals are paid under exceptions to the basic payment formula. The IOM Committee made several recommendations to improve the accuracy of the payment adjustments, including a refined process for "smoothing" the differences in payments to hospitals that lie on different sides of geographic boundaries.[v] The

Committee concluded that if these improvements were made, the need for most, if not all, of the reclassifications and exceptions would disappear. This is the best example of the case for improving a payment system rather than piling exception on top of exception until the integrity of the payment formula is dangerously undermined.

Not surprisingly, IOM Committee expects that its recommendations will be met with some resistance from hospitals that would do less well under a more accurate system of payment adjustments than under a continuation of whatever exceptions they have been granted. Almost all of the Committee's recommendations would require new legislation. Exceptions like the Section 508 policy create constituencies for their continuance and expansion, and that works against efforts to improve the payment systems as an alternative to extenders.

Many rural provider provisions undermine payment formula integrity. Many of Medicare's exceptions and extenders appear to be designed to prop up payments to rural providers. These provisions include ambulance add-on payments, pathology and clinical laboratory payments, outpatient hold-harmless payments, and payment floors in both the hospital and physician fee schedule geographic adjustments. I believe that the Congress should be skeptical about the need to increase payments to rural providers and apply the criterion I'm suggesting of a "compelling and substantial beneficiary need." In addition, I believe it is harmful to alter payment formulas to, for example, improve beneficiary access to care in rural areas. If subsidies are needed to improve access, and I am not convinced they are, it would be much better to address the matter directly rather than undermine the integrity of Medicare's payment formulas. Imposing floors in the geographic adjustments, in particular, makes no sense. It not only perpetuates a Lake Wobegon-like world in which no one can be below average, it also reduces the accuracy of payments to all providers because of the need to readjust all provider payments in order to "pay for" the floors. Although there are ways to improve the accuracy of the payment formulas, floors and other exceptions, if extended, tend to reduce the value of such improvements.

Medicare needs a payment system for outpatient therapy. Several years ago, in response to a mandate in the Medicare Modernization Act of 2003, GAO

conducted a study of outpatient therapy services – physical therapy, occupational therapy, and speech-language pathology services.[vi] Congress had established per-person spending limits ("caps") in 1997 in response to rapid spending increases, but then placed a moratorium on the caps for several years. GAO recommended that, while the Centers for Medicare & Medicaid Services (CMS) worked on the development of an outpatient therapy payment system, it develop an interim process for granting exceptions to the caps. A process was put in place and today such exceptions are routinely granted, and the process routinely extended. What's missing is a payment system that bases limits on outpatient therapy on individual patient condition, which GAO recommended in 2005. Without such a system, Congress is faced with the prospect of extending an expensive policy without knowing whether, and to what extent, additional services are "reasonable and necessary" or simply add to Medicare's spending problem.

Medicare should not pay twice for the same services. Another congressionally-mandated study by GAO examined the widespread exception to the hospital PPS payment rules that allows laboratories that provide outsourced pathology services to bill Medicare directly.[vii] Because the PPS payment is supposed to cover all of a patient's services, this exception constitutes double payment for the outsourced services. GAO could find no evidence of an effect of this policy on beneficiary access to services and recommended its discontinuance in 2003. Like many others, however, this policy has been extended multiple times.

Congress Should Encourage CMS to Improve Its Payment Systems and Providers to Become More Efficient Rather than Grant and Extend Exceptions. The examples cited above as well as others not discussed today make me very skeptical about the need to grant and extend exceptions to Medicare's payment systems. The extenders are not only expensive in their own right, but also have the unintended consequence of undermining the integrity of the payment formulas and exacerbating the incentives of fee-for-service payment to drive volume and spending upward. I believe that Congress should apply a high standard in determining which, if any, of these policies are both affordable and meet a compelling beneficiary need.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions that you or Subcommittee members may have.

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[i] See, for example, Elmendorf, D. "Confronting the Nation's Fiscal Policy Challenges," Testimony before the Joint Select Committee on Deficit Reduction, U.S. Congress, September 13, 2011.

[ii] Providers often assert that Medicare payments are inadequate to cover their costs, but see Anderson, G., et al., "It's the Prices Stupid: Why the U.S. is so Different from other Countries," *Health Affairs*, Vol. 22, No. 3, 2003, pp. 89 – 105, and Laugesen, M.L., and Glied, S.A., "Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services Compared to Other Countries," *Health Affairs*, Vol. 30, No. 9, 2011, pp. 1647 – 56, for evidence that providers are paid more in the United States for similar services than in other countries.

[iii] See, for example, Government Accountability Office, "Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices." Washington, DC: GAO, 2008, which presents evidence on the relationship between fee-for-service incentives and expenditure growth. See also Medicare Payment Advisory Commission, "Report to the Congress: Medicare and the Health Care Delivery System," Washington, D.C., June 2011, and MedPAC's prior annual March and June reports to the Congress for discussions of how fee-for-service incentives drive health care spending.

[iv] Congressional Budget Office, Reducing the Deficit: Spending and Revenue Options." Washington, D.C.: CBO, March 2011.

[v] Institute of Medicine, "Geographic Adjustment in Medicare Payment: Phase I: Improving Payment Accuracy." Washington, D.C.: The National Academies Press, 2011.

[vi] Government Accountability Office, "Medicare: Little Progress Made in Targeting Outpatient Therapy Payments to Beneficiaries' Needs." Washington, D.C.: GAO, November 2005.

[vii] General Accounting Office, "Medicare: Modifying Payments for Certain Pathology Services Is Warranted." Washington, D.C.: GAO, September 2003.

Chairman HERGER. Thank you.

Mr. Umbdenstock, it is my understanding that hospitals that go through the standard wage reclassification program must reapply every 3 years. As part of this process, hospitals must prove to CMS that they have increased their wages and are paying wages that are similar to those of nearby hospitals.

I have had a case in my own district where a hospital lost its reclassification and millions of dollars in Medicare payments because its wages did not meet the required threshold. Is it fair that Section 508 hospitals do not have to reapply like other hospitals do and are simply given the higher wage rate if Congress extends the policy?

Mr. UMBDENSTOCK. Thank you, Mr. Chairman.

I do think that it is important to understand that the original reason for Section 508 was because these were areas and hospitals in areas near higher-paid areas that failed to qualify in that criteria, kind of near-miss situations. So they have already demonstrated that they are close to the wages—more similar to the wages in the areas into which they are reclassified than the one in which they are presently residing. So, under this program, it does fill that kind of gap for them.

Now, as this provision moves along, we certainly do want to see it extended once again to take care of that problem. But it is their first intention to go through the regular wage process, wage adjustment process, to see if they can qualify there before they turn to this.

Chairman HERGER. Is it fair that Section 508 hospitals do not have to prove that they are in fact using extra money to increase wages to nurses and other patient care and staff?

Mr. UMBDENSTOCK. Well, that is—the wage and benefits are two-thirds of a hospital's annual budget. And it is the hardest place for them to keep up now because of shortages of personnel and increasing market competition for those people. So that is where moneys are going for the average hospital. They are all facing significant shortages and use this money for that purpose.

Chairman HERGER. Again, unlike these other hospitals, they don't have to prove it. That it is something that has been automatic. Is that not correct?

Mr. UMBDENSTOCK. I would have to ask my staff to double-check me before I give an answer.

That is correct; they do not. Thank you.

Chairman HERGER. You testified also that there are 258 rural hospitals that benefit from the outpatient hold harmless payment. But according to CMS, there are more than 900 rural hospitals that are potentially eligible for the hold harmless payment but have not received it because their aggregate outpatient PPS reimbursement is higher than their costs. Can you explain why the outpatient PPS is sufficient for some similarly situated rural hospitals but not for others?

Mr. UMBDENSTOCK. No, I don't think that there is a particular across-the-board explanation for that or rule of thumb. I think these are situations where they find their costs to be significantly more than the payment and need that type of assistance in order to try to narrow that gap; 258 is the number of hospitals as of 2010 that have qualified for that. But I would have to get back to you, sir, on exactly why—if there were major reasons why the others were not—were so much more above that.

Chairman HERGER. Thank you. I would appreciate it. If you would do that, please.

Mr. Steinwald, you note in your testimony that Congress should be cautious about extending these payment policies. By what criteria should each extender be judged, in your estimation?

Mr. STEINWALD. Yes, Mr. Chairman. Thank you. I would say three criteria: The one I mentioned before is affordability, the extent to which an extension might contribute to Medicare's financial spending problem.

And let me say offsets are nice. I appreciate you have asked the witnesses to think about offsets to the extension of expiring provisions, but Medicare needs savings, Mr. Chairman. I wouldn't let the availability of offsets reduce your skepticism about the need to extend these expiring provisions.

Then I think there ought to be a compelling beneficiary need at the foundation of an extension. And I think you ought to be looking at whether or not an exception is the way to address it or an improvement in the payment system is a better way.

Chairman HERGER. Thank you.

Mr. Stark is recognized for 5 minutes.

Mr. STARK. Thank you, Mr. Chairman.

First of all, I think you all heard this before, but I am charged with asking you that if there is anybody among you who feels that any savings that we get should first go toward strengthening the Medicare program and not go to the general deficit reduction. Anybody disagree with that on the panel?

Let the record show, Mr. Chairman—you disagree with that, Mr. Steinwald?

Mr. STEINWALD. Well, when you said any savings should strengthen the Medicare program.

Mr. STARK. The Medicare savings.

Mr. STEINWALD. I would disagree with the blanket statement that any savings should strengthen. I think Medicare does need savings that contribute to reducing the deficit.

Mr. STARK. You would pick and choose.

Dr. Wah, as I understand it—you mentioned the GPCI issue—physicians are paid, one, for the medical procedure and, two, generally for office expense, in other words, the cost of rent, malpractice insurance, help in the office, and so forth. Is there any reason that a physician should be paid, let's say, for a tonsillectomy any more or less in New York than in Wapakoneta, Ohio? Same procedure. Same training. I would assume that that part of the physician reimbursement should be standard across the country.

Dr. WAH. I believe—thank you for that question. I think what you are asking, in the current environment, because we have a resourced-based payment system, what you are describing is essentially the basis for the way we are doing it. In other words, what resources does it take to deliver the service?

Mr. STARK. No, that is a separate payment. I am just saying that a doctor is trained and I presumed licensed to perform a procedure. Pick whichever one you want; removing a plantar wart or whatever. Is there any reason that that shouldn't be the same payment across the country?

Dr. WAH. If we could isolate that part out.

Mr. STARK. Oh, we do that now.

Dr. WAH. I know there is a number of attempts to try to do that accurately, but there are some problems with that. So there are—there is the belief that if we could just get to the part where, as you say, taking off the wart or taking out the tonsil is the same, regardless where in the country it is, we should reimburse that exactly the same. I think that is what you are advocating.

Mr. STARK. I don't think there is any reason that it would be different.

Now, the cost of operating the practice, as I said before, insurance, rent, that differs all over the country. We have attempted to adjust that for the physicians. But I just wanted, if we could establish somehow that for a particular procedure across the country, pay the same. Then we get to the issue of facilitating the physician's ability to provide that procedure, depending on geographic conditions or economic conditions or if they are in a rural area and a whole host of issues. It seems to me that with that, we kind of have to push you guys to get your RUC ideas back as quickly as you can so we know what those should be. But the practice expense is the big gorilla that we have to wrestle with.

From my experience, this is largely an accounting question. It does cost more for rent, I am sure, in some areas that are rural areas or in rural areas where somebody has to cover a host of different places. So if we could encourage the AMA to help us to set the payment on the procedures, then I think we could get a long way toward properly reimbursing physicians, not necessarily with desired payment but maybe with reasonable payments.

Dr. WAH. And to be clear, the AMA does not set payments. We wish we did. But we don't. This is not our job in this process, Congressman. CMS sets the actual payment. What we have done is set up a process by which we relatively weigh the various procedures.

Mr. STARK. And you are in the process of revising that now, are you not?

Dr. WAH. We are always constantly reviewing this relative value scale by which we have been working for a number years. And we bring together experts from around the country to do that. The AMA does that without costing the taxpayer any money. We do that on our own expense. But we believe it is important physicians do that as opposed to some other entity that may not understand the nuances of health care as well as physicians. I just want to be clear, we are not setting payment.

Mr. STARK. We look forward to your next report.

Dr. WAH. Now the GPCIs are important because, as you pointed out, there are wide variations in practice expenses. Also, as most everyone knows in the country, those expenses are not going down, most are going up. Whether they be rent or salaries or insurance, all of those factors are being increased. That is why it is important that we have the ability to see those things increase.

Mr. STARK. Thank you.

Chairman HERGER. The gentleman from Texas is recognized, Mr. Johnson, for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Steinwald, I appreciate your testimony and the questions you feel Congress needs to ask before extending some of these policies.

In looking at pathology in particular, you note in your testimony that Medicare should not pay twice for the same service. Can you explain how this can occur under the pathology services exception that GAO studied?

Mr. STEINWALD. Yes, sir.

When we looked at this I believe in around 2003, what was happening at the time is that many hospitals were outsourcing certain tests to be performed by independent laboratories. Those independent laboratories were permitted to bill Medicare directly and get paid directly.

Well, under the inpatient prospective payment system, the DRG payment is supposed to cover all of the patient's care, including any testing. And so when I say it is paying for it twice, what I mean is the hospital is getting paid a DRG payment, a single payment for the entire care of the patient, and at the same time, these outsourced medical tests are being billed and paid for separately.

Mr. JOHNSON. Thank you.

Dr. Wah and Mr. Umbdenstock, outside of labs and certain facilities, no other supplier can bill Medicare directly for services provided in the hospital setting. How can Medicare be sure it is not paying twice for pathology service under both IPPS and by allowing independent labs to directly bill? He just talked to that.

Dr. WAH. I think we are not talking about all laboratory services. Pathology services are those that examine tissue that is taken out at the time of surgery, some sort of tissue analysis. And in many hospitals, those facilities are not available in the hospital. So they need to essentially go outside the hospital for those services.

Mr. JOHNSON. How many hospitals don't have that ability? All the ones in Dallas that I have been to do have it.

Dr. WAH. I have to leave that detail to—I want to be clear we are not talking all laboratory services or even all pathology services. It is those where the hospital does not already have that ability within the hospital itself, so it is going outside to get those.

Mr. JOHNSON. We should be sure they are not billing twice.

No, we can't. You are right. You answered it.

If that provision were to expire, would the patients experience a gap in care that didn't previously exist.

Mr. UMBDENSTOCK. If I may take a pass at the first question as well. For many times over now, those costs, at the direction of HCFA and then CMS, have not been included in the hospital's calculations. So they were not built into the rate. It was expected that they were going to be billed separately.

Now, to how many hospitals would not provide the service if this was not allowed, I really can't answer—I think that was your second question, sir—I can't answer that. I can't project that. But we do know that many of them have gone out for independent services because they don't have the volume or in some cases can't afford to maintain the staff and the service. And so they have contracted out to someone who can service a lot of hospitals and put that volume together and make it economically worthwhile to do so.

So we know that that was the original reason. And it would only, in my mind, it would only stand to reason that more would opt out because they couldn't afford to do this on their own. They couldn't

afford the building systems and so on. So I think it would further exacerbate the problem.

Mr. JOHNSON. Thank you.

Mr. Williamson, thank you for being here. Can you provide some insight into the figures you mentioned in your testimony, such as the 22.6 percent addition to the base payment rate for ambulance services to remote areas, and how are those numbers generated, and do you feel a fixed-rate adjustment is appropriate for a service that seems to be variable in regards to time and distance?

Mr. WILLIAMSON. The issue of how that was derived was from the study from the GAO office. The reason for the drastic difference in cost is, of course, the geographic area, which the ambulance—super rural ambulance service covers, and the population density. There is so much fixed cost and readiness cost involved in providing ambulance service on a timely fashion, that geographic density plays a huge part. So it was determined from those cost studies in the GAO report how much that should be and why it was so drastically more than urban or a less rural area.

Mr. JOHNSON. Okay. I am not sure I know why the difference is there. But thank you for your testimony.

I yield back.

Chairman HERGER. Thank you.

Mr. Thompson is recognized for 5 minutes.

Mr. THOMPSON. Thank you, Mr. Chairman.

Thank you to all of you for being here to testify.

Mr. Moore, I appreciate your comments on the therapy cap. I think that has been a huge issue, and it has really prevented a lot of folks from getting treatment that they really needed to get. I am glad that you raised that issue.

Mr. Steinwald, you mentioned that we really need to take a close look at these extenders. Were you talking about all of the extenders? Because the SGR issue, I think that is pretty universally accepted that we need to figure out a better way to deal with that. That is something that not only puts providers in a bind, but patients as well. Do you classify that the same as all of the other?

Mr. STEINWALD. It is the big dog, for sure.

Mr. THOMPSON. I know it is the big dog, in more ways than one.

Mr. STEINWALD. I was asked in my statement to exclude any comments about Medicare Advantage and also SGR. So I would be happy to talk with you at length about SGR in another setting.

Mr. THOMPSON. You weren't including that with the long list of extenders that we may or may not be talking about today.

Mr. STEINWALD. No. But by excluding it, I don't mean to imply that I think you should just repeal it.

Mr. THOMPSON. We should just——

Mr. STEINWALD. Repeal SGR.

Mr. THOMPSON. I wasn't talking about repealing it. I was talking about addressing the issue of payments to providers and the impact that has, not only on them as providers but also the people that rely on medical services.

Mr. Williamson, thank you for raising the issue of the 22.6 percent super rural add-on payment. I know that in my district, I heard from a lot of ambulance providers who really took a hit be-

cause this was done in a way—done retroactively, and folks had to wait a long time to get their payment. And it really put them in an economic bind. Some of the providers in my district actually had to take out loans in order to keep their business afloat while they were waiting for the reimbursement that they were certainly entitled to that.

I just want to hear from you exactly the impact that that has had on the people that you represent as well as the people that they service.

Mr. WILLIAMSON. Well, it, actually, was a devastating situation for many services, some of which had to close. In other situations where they had to reduce staff, it forced other services to cover a larger area, which then means the patient received a longer response time. So it had a major effect also on enhancement of the services, whether it be more medics or newer equipment. That short period of time set them back longer than the 3 months it took to receive the funds. It stopped all planning and anticipated growth.

Mr. THOMPSON. I just think we need to pay particular attention to that because the whole idea of retroactive payments, this is a real clear case of how it hurts providers. But it is across the board. Any of the folks that you represent at this dais today, when they are dealing with retroactive payments, it makes it very, very tough.

Mr. Williamson, does your organization include firefighters, county health departments, and public hospitals?

Mr. WILLIAMSON. Yes. We represent all facets of the industry.

Mr. THOMPSON. I was a little surprised to hear that you kind of tout the Health Care Leadership Council's Medicare proposals. I think you said they were worthy of consideration. Part of that proposal includes some pretty drastic changes in Medicare and some would say actually pave the way for the Ryan voucher program that we have had hearings on. Is this something that your membership supports? Has this been vetted through your membership?

Mr. WILLIAMSON. No, it has not. We haven't formally endorsed that program—those recommendations—but we thought several of those had merit and that it should be looked at and studied.

Mr. THOMPSON. Why did you feel compelled to tell the committee that you thought that this move toward voucher was an appropriate way to go?

Mr. WILLIAMSON. Well, we didn't mention the particular aspect of that program that talked about vouchers. We talked about—also, we brought up the legislative reform as far as the court issues. And then on the Medicare programs, where they could competitively shop for a better service, we thought that was a plausible position to look at for reduction.

Mr. THOMPSON. Thank you.

Chairman HERGER. Thank you.

Mr. Buchanan is recognized for 5 minutes to inquire.

Mr. BUCHANAN. Thank you, Mr. Chairman, for this important hearing.

I would also like to thank all of our witnesses.

We have touched on extenders a little bit. I want to talk, mention to Mr. Umbdenstock, I think I read in your testimony you had mentioned that you are encouraging Congress to enact robust medical liability reform to eliminate a lot of frivolous lawsuits. I know in our area in Florida, when I talk to doctors or hospitals or anybody that is involved in the medical field, they just feel like that is the low-hanging fruit, and it can make a big difference. I know that Texas has a cap of $250, and they just got loser pay I think September 1st. That will make a big difference.

We have a lot of doctors or people going to medical school. They are going to look at where they have got the best opportunity. If know I have a neurosurgeon in my area that suggests that he is paying $200,000 a year for med mal liability insurance.

I was just wanting to know, from your standpoint, what kind of savings do you think we would get? I guess there are two aspects—the immediate savings, but also in terms I hear a lot from the doctors about defensive medicine, doing a lot of unnecessary tests that they wouldn't have to do otherwise.

Mr. UMBDENSTOCK. Yes. To that, we have long supported liability reform at the American Hospital Association and continue to do so. I think it is a very important area for a lot of reasons, not the least of which certainly in dollar terms is the whole issue of defensive medicine and how that drives up utilization, drives up costs. But it also would have an indirect benefit, too, of helping out to the physician side and the hospital side of lowering their expenses, lowering the overall costs of the Medicare program. So we think there are both direct and indirect benefits to it.

It has been scored up in the $60 billion range over 10 years. We think that is a very important source of money to put to better use across the system.

Mr. BUCHANAN. Again, that is what I hear every day any time I meet. We have medical societies in each of our communities. That is their biggest issue.

Dr. Wah, what is the AMA's position today on medical reform, tort reform, legal reform, getting rid of junk lawsuits, frivolous lawsuits. What is the position of the AMA?

Dr. WAH. Thank you for bringing up that important issue. Clearly, medical liability reform is an important reform that we believe needs to happen in this country for our physicians but also for our patients. Mr. Umbdenstock talked about the $60 billion the CBO scores for that. We are hoping the supercommittee in their deficit reduction process looks at that $60 billion as a way to get towards their $1.2 trillion.

But also, let me just point out for our patients, beyond the cost of the additional tests, the unnecessary tests to get done in defensive medicine, there is a human cost as well. Everyone knows it is not easy to go get an extra blood test, an extra x-ray, or another kind of exam. So there is more than just the financial cost that we are concerned about here. Those tests have a human total as well. And there are increased risks when they have the additional procedures and tests. So we are very concerned about that. It seems to us that there are a lot of dollars that get spent in this area that can be spent better on medical care as opposed to just simply pro-

viding some sort of defensive process against frivolous lawsuits, as you pointed out.

Mr. BUCHANAN. When the AMA throws out a number of $55 billion or $60 billion, does that include—are you estimating defensive medicine in there as part of that?

Dr. WAH. That number is actually I think from CBO, not from us. I am just saying what CBO scored. I think it is $63 billion of potential savings.

Mr. BUCHANAN. Does that include defensive medicine?

Dr. WAH. A lot of that part is defensive medicine, yes.

Mr. BUCHANAN. Mr. Steinwald, do you want to comment on tort reform, legal reform?

Mr. STEINWALD. The CBO estimates, the way you get savings is they estimated there would be one-half of 1 percent effect on spending under Medicare with this reform. Now, for years, they were reluctant to come up with an estimate like that. But they did so recently.

So you get less Medicare spending. You also get added revenues because the estimate would then cause private employers to spend less for their health care benefits for their employees and therefore divert more money into taxable wages.

Mr. STEINWALD. So you get a spending reduction, and you also get some additional revenue. I don't know that——

Mr. BUCHANAN. You mention affordability. Do you have a sense of a number or a thought on that in terms if we had material tort reform like Texas seems to be moving towards, savings that we would have?

Mr. STEINWALD. Well, I would go with CBO. I mean, they are the ones who have the wherewithal to make these estimates.

And, once again, I would say if there are savings to be had, they don't necessarily have to be used in order to pay for extending expiring provisions.

Mr. BUCHANAN. Thank you. I yield back.

Chairman HERGER. Thank you.

Mr. Kind is recognized for 5 minutes.

Mr. KIND. Thank you, Mr. Chairman, and thank you for holding this important hearing.

I want to thank all the witnesses for your testimony here today. It is very helpful.

Let me just ask you all just a general question. Because I happen to believe and I am kind of a disciple of the Dartmouth Atlas studies that come out in regards to utilization practice of health care throughout the country. I believe if we are ever going to get a grip on the rising cost of health care, especially the impact it is having on both public and private budgets alike, we are going to have to change the way we pay for health care in this system in this country. We have got to move away from the fee-for-service system, paying for tests, procedures, things being done, and instead move to a fee-for-value payment system.

Mr. Steinwald, I want to thank you for serving on the first IOM panel. I know you have been tasked to do a lot in upgrading the Medicare reimbursement formula with the two phases. The second one I understand will be released next week.

But many of us who pushed for those studies to come out, for this one in particular, viewed it as just a bridge to the second IOM study. That second IOM study is tasked to change the fee-for-service system under Medicare to a fee-for-value reimbursement system, and they are supposed to present an actionable plan to IPAB and also the Congress on how this can be done.

I think that ultimately needs to be the goal when it comes to health care reform so we can get out of the SGR problem. We can get out of hearings like this talking about tweaking the reimbursement for procedures, for particular exceptions that you have talked about and written about. Otherwise, we will be here years later having these same type of hearings without making any real meaningful payment reform.

Dr Wah, I know the physicians of the country, too, have embraced more quality measurements and outcome-based practice. How important do you think will it be for us to convert fee-for-service under Medicare to an outcome-based reimbursement system?

Dr. WAH. Thank you for that question.

I 100 percent agree with you that what we need to do is revamp the Medicare payment system, in particular the physician payment system. As I said before, all of these patches that you are talking about, all of these extenders—and I have used the example with our staff—it is like all the little patches you have on a leaking boat. What you really need is a new boat. You can't take the patches off the boat, because it will leak even worse. So you are, unfortunately, stuck with all the extenders because of the problems you have got with the boat. But what is really needed is a new boat.

The other way to put it for the physicians in the audience is we have get a lot of symptoms here that we are treating but not the underlying disease. The underlying disease is we need a new system.

I would say as a physician what we need to talk about first is a new way to deliver health care. So it is delivery reform first and payment reform second. What you should do is have an ideal delivery reform and then find a payment system that facilitates that ideal delivery, and that is what we are looking to do here.

Mr. KIND. It seems——

Dr. WAH. Before we do that, we have to get rid of the SGR. As somebody said, a dog or a big dog or any kind of dog, it is clearly what has to be done first. That has to be removed.

Mr. KIND. I would agree with you on that.

Dr. WAH. Then we have to then go back and have some stability while we figure out what the ideal delivery system is. As I said before——

Mr. KIND. The SGR—you are right—has been patently unfair to the practicing physicians around the country. For them to be held hostage year after year expecting a patch or something to be worked out in the eleventh hour, it is just too much unpredictability and angst within the medical profession.

But it sounds like you just described the Affordable Care Act, trying to do system delivery reform and then also payment reform in future years. Because we all understand we are not going to change the way you pay for one-fifth of the entire U.S. economy overnight. It is going require a period of transition.

Yet my fear with the Super Committee and all this deficit reduction pressure that we have around here is we are in a race against time right now for just draconian, across-the-board cuts in Medicare or health care spending generally, regardless of the consequences, regardless of the implications that it will leave patients throughout the country, rather than allowing these reforms to move forward on how health care is delivered but ultimately how we pay for it.

Mr. Umbdenstock, let me ask you in regards to some of the exceptions with rural providers, because the margin for my hospitals in rural western Wisconsin are very thin to begin with. What would happen if the exception for rural reimbursements were to be eliminated overnight?

Mr. UMBDENSTOCK. Oh, I am very fearful because of the situation that you describe about those thin margins. We know they take care of a very small population basis. We know they are very essential because of the great distances to other services. So, yes, I think it would put an already strained system under much greater strain; and I agree with the leaky boat analogy. We are living with these now because the fundamental system is flawed.

To your first question, sir, I, too, would agree, the American Hospital Association agrees, we have got to move toward a value-oriented system. The challenge is to learn how to get there and to do it right while maintaining the current delivery system that we have, make sure it is viable in that transition period, but on a principled basis get to a point where pay for performance is fully supported. Exactly what the measures are and exactly how they get used and how we account for differences in different population segments, yet to be worked out.

Mr. KIND. I agree with that.

Thank you, Mr. Chairman.

Chairman HERGER. Dr. Price is recognized for 5 minutes.

Mr. PRICE. Thank you, Mr. Chairman; and I want to thank the panelists as well for their testimony.

I think it is important to appreciate what we all want is the highest quality of care to be able to be delivered to the citizens of this great country, and I would suggest that every exception that has been put into place was an attempt to get a higher quality of care to the patient. So there was a rationale behind each and every exception. Obviously, this has gotten way out of hand, as the testimony of all of you demonstrates.

Can we agree that the Medicare payment system is broken?

Everybody agrees the Medicare payment system is broken.

All right. I want to touch on a couple of specific—which means we have to reform the Medicare system completely. I want to touch on a couple of issues and then ask a couple of specific questions.

First, lawsuit abuse was touched on, the practice of defensive medicine. CBO scores it, says that if you fix it, it will save $60 billion. There are quality studies to demonstrate the practice of defensive medicine is in fact greater than $60 billion, in fact, in the hundreds of billions of dollar range if in fact you reform the lawsuit abuse issues in responsible ways. So I think there is a lot more savings there.

Secondly, this pay for value sounds wonderful. It sounds just grand. But as a practicing physician I can tell you that what is of value to one patient may be different than what is of value to another patient. And so having us in Washington decide what is of value is very, very troubling to me; and I think we need to keep that quality care for each individual patient at the heart of what we are talking about.

Mr. Steinwald, you talked about, in response to a question on what criteria we ought to use to continue an exception, you mentioned affordability being one of them. I assume you are talking about the Medicare program. If the Medicare doesn't program doesn't have enough money to provide a certain service, do you believe that a Medicare patient ought to be able to privately contract with a physician for that service if Medicare can't afford it?

Mr. STEINWALD. Let me think about that for the next 2 weeks.

Mr. PRICE. Great. Free decision between one citizen and another citizen to contract for a service, you are not certain about.

Mr. STEINWALD. No, I am not sure that one would need to go that far in order to make an improvement.

Mr. PRICE. But in principle, in principle.

Mr. STEINWALD. I am not so sure. I can see the arguments on both sides.

Mr. PRICE. Dr. Wah, I want to get right to the issue of the fundamental reform that is necessary. All of these exceptions, as I mentioned, I think were trying to provide a higher quality care for patients. But what you mentioned I think is incredibly important for us to concentrate on. That is that the system is broken and needs to be reformed. Is it your position or the position of the AMA that if we have a reasonable, responsible payment system that none of these exceptions would be necessary?

Dr. WAH. Thank you, Dr. Price.

Obviously, what I said before is I think we have got a problem with the entire system; and that system that is broken has led to all these patches that we are talking about today. So, yes, absolutely, we believe the Medicare payment system has to be redone.

But we need stability while we are redoing it, because it can't be redone overnight. That is why in that three-pronged part that I talked about in my testimony, first we need to repeal the SGR, just flat out repeal it. And then there has to be some period of some 5 years, we have estimated, of stability while we develop a new system that does in fact deliver high-quality care in a cost-effective manner to as many patients as possible.

And so we think that 5 years of stability, with recognition that costs are going to increase, as the chairman said. There the cost of your rent, your insurance, your personnel. We need to have escalators that cover those increasing costs. But 5 years of stability in the system while we develop the new system.

And then develop a new system that is equitable for all participants in the system, and that is what we are looking for. I think if we did that we wouldn't come back year after year for this exact kind of hearing where we are looking at this huge number of little patches on the leaky boat.

Mr. PRICE. So if I am hearing you correctly, what you are saying is if we have a system that is flexible enough and responsive

enough to patients and physicians, then these kind of exceptions could go away.

Dr. WAH. Absolutely.

Mr. PRICE. I just want to have you respond, if you would, to the same question I asked Mr. Steinwald. That is, if we are going to confine what Medicare patients can receive based upon the amount of money available, which is a reasonable thing to do from the Federal Government's standpoint, if a Medicare patient is told they can't receive a service in that program because there is not enough money, do you believe as a physician and as a representative of the AMA that that patient ought to be able to contract with that physician for that service?

Dr. WAH. Absolutely. There is AMA policy supporting that. I mean, I support it as a physician. I support it as an American that believes in such fundamental freedom that we ought to have the ability to contract for our services in a way that everybody else can in this country.

I appreciate your efforts in this regard in the bill you have already put in. So, obviously, we are very supportive of your bill and the companion in the Senate; and we are looking for cosponsors wherever we possibly can.

Mr. PRICE. Mr. Chairman, I yield back.

Chairman HERGER. Mr. Pascrell for 5 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman.

In response to the last series of questions, I would conclude myself, Dr. Wah, that those that can afford it might look for private assistance but not the majority of those on Medicare. So you can deal, I think, with the majority or you could ignore them that will not go to seek other care if Medicare is not there. I think you would agree with me on that, wouldn't you?

Dr. WAH. I don't think it is an either/or, sir. I think it is an option that acts a little bit as a safety valve on a process that clearly is not working today where there is not adequate payment for some of these services. It allows the physician and the patient to form a companion contract to make up that difference.

Mr. PASCRELL. But do you think the majority of Medicare patients fit into that particular group of people that we are talking about?

Dr. WAH. I don't know about majority. I think there are a number of examples where, just like anywhere else in our economy, there are patients that want to procure services and they are willing to pay for it, but they are currently precluded from using their Medicare benefit which they paid into their entire life because of these rules that don't allow for them to have any kind of additional contracting outside the Medicare agreement that is with the physician.

Mr. PASCRELL. Do you think that the Super Committee looking at many—the Medicare problems that we have to address, such as you just talked about it, the physician fix——

Dr. WAH. Well, actually, sir, it is the SGR fix. Physicians are fine. We don't need fixing.

Mr. PASCRELL. How does that contribute to the deficit, Dr. Wah?

Dr. WAH. I think the SGR is becoming—as you all realize, for 10 years, Congress has had to go back and patch the SGR system, freeze payments, and they never finance it. They never paid for it in an accounting way. They never really accounted for it on the books. So, right now, there is about $300 billion that are hiding in the books; and that is really not honest accounting.

Mr. PASCRELL. How would you suggest we——

Dr. WAH. I think the deficit reduction committee, the Super Committee we are talking about, really has an opportunity here to bring forward honest accounting and account for this 10 years of kicking the can down the road and making the problem bigger. In 2005, the SGR could have been fixed for about $48 billion.

Mr. PASCRELL. Correct.

Dr. WAH. Now we are talking just $300 billion, and in 2016 we are looking at probably $600 billion to fix our problem. None of that is showing up on the books.

Mr. PASCRELL. Well, we tried to do that. Dr. Wah, as you remember the debate that went back and forth, we tried to do that at that time.

I want you to make clear to me, what do you think that Medicare savings, those that were reported to happen and those we hope to happen, I think that they should first go towards fixing these Medicare problems we have been talking about, not to outside programs. Would you agree?

Dr. WAH. Certainly as a physician taking care of patients——

Mr. PASCRELL. You think that would be a good idea, Dr. Wah?

Dr. WAH [continuing]. High priority, yes, absolutely.

That is not my call. I think that is your call to decide where those savings go. But certainly from my standpoint I think patient care is very important, and Medicare provides a system that gives care to a large population. That is important as well.

Mr. PASCRELL. Mr. Moore, one quick question—thank you, Doctor—about traumatic brain injury. As the co-chair of the Congressional Brain Injury Task Force, can you tell me how important it is for those patients to be able to access therapy and how these therapy caps negatively affect brain injury patients?

Mr. MOORE. Thank you, and appreciate all your leadership on that issue.

The patient with traumatic brain injury is a great example of a patient that would be adversely affected by these arbitrary financial limits, those patients with complex, high-need, high-rehabilitation-need diagnoses, especially if they need multiple services. As we said, the therapy cap is currently a shared cap between PT and speech language pathology. An individual with brain injury would need both those distinct professional services. And so that is one of the key diagnosis that benefits from having care above that cap.

Mr. PASCRELL. Thank you very much.

Thank you, Mr. Chairman. I yield back.

Chairman HERGER. Thank you.

Mr. Gerlach is recognized for 5 minutes.

Mr. GERLACH. Thank you, Mr. Chairman. I am going to try to be quick with my questions, given where we are with votes over in the Capitol.

First, Mr. Umbdenstock, real quick question with regard to Section 508. I have a situation in my district a few years ago where Reading Hospital in the City of Reading, about 60 miles from the City of Philadelphia, had an application in for hospital wage reclassification, because of the fact that it competes so heavily in that metropolitan statistical area for all the hospital staff. So they are competing with Philadelphia-area hospitals every day for good quality staff, and they were successful in getting a wage reclassification, which is a good thing.

And yet there seems to be examples, too, one in Burlington, Vermont, which is 216 miles away from Boston, that also got a reclassification even though it is probably not likely that someone from Burlington is going to travel 432 miles every day to go to work in Boston on a round-trip basis.

So what would your suggestion be if we are looking at the extension or continuation of the reclassification system? What would be a good way from a geographical proximity standpoint to tighten up how that reclassification determination is made?

Mr. UMBDENSTOCK. Yes, Congressman. Actually, the American Hospital Association has now under way a task force on the area wage index. We will be studying it with 20 or 22 of our members very closely over the coming year to come up with exactly those recommendations.

I think in the example you cite, certainly 60 miles is a commutable distance in the common labor market, but 240 or 250 miles may not be commutable but it is in terms of attempting to attract and recruit and retain staff at a level for that particular medical center. So there may be a very high-intensity type of organization that recruits in the greater Boston teaching hospital, greater New York teaching hospital types of markets.

So our markets in health care, when you get to the advanced level of service, really becomes even more than regional. It becomes national. So it isn't necessarily by zip code or by county or even by urban area. The competition and the recruitment goes on nationally.

Mr. GERLACH. Mr. Moore, thank you for your help on the therapy cap legislation, a very important piece of legislation to move forward and consider. Because, as you said, it is an artificial cap on the ability of very needy patients to get the care they need, if they happen to need care a little bit more than $1,870 a year.

So as you continue to work on that issue and all of you gentlemen continue to work on these issues and whether the reimbursements are right or not, what we are not talking enough about either, it seems to me, is the current waste and fraud in the system. That if you identify that, deal with that, and then therefore save those dollars from being wasted or fraudulently taken away, it can be used to better fund the kind of services, Mr. Steinwald, you say should be funded, even though it might be more costly to the system.

There is legislation in the Senate by Senator Kirk and Senator Wyden, Senate Bill 1551, I would appreciate if you take a look at and get back to the committee on your position on it. It would set up a common access card for Medicare patients as well as for the providers, creating a biometric system for the providers to assure

that the providers are really the ones who ought to be providing Medicare services to that beneficiary, the beneficiary having like a debit card, a number card with a pin, to make sure that person is the right person to be receiving those services.

It is estimated that in 2010 by the Office of Management and Budget there was $48 billion in improper payments in the Medicare system in 1 year, $48 billion. Now it seems to me that is a lot of money that could be used to make sure people are getting the therapy they need, physicians are getting proper reimbursements for services they provide, hospitals the same, ambulance services.

So we ought to be talking more not just about the amount of reimbursement but why there is so much waste and abuse and fraud in this system that we don't have the dollars to do really what should be done in getting care to patients. So if you gentlemen could take a look at that legislation and get back to the committee, it would certainly be appreciated.

With that, I yield back. Thank you, Mr. Chairman.

Chairman HERGER. Thank you.

And I want to thank each of our witnesses for your testimony and your insight, your participation was integral to helping us understand the history of these expiring provisions and the impact they have on providers. I know the information we learned from this hearing will be a good starting point from which to further assess each of these expiring provisions before the end of the year.

As a reminder, any member wishing to submit a question for the record will have 14 days to do so. If any questions are submitted, I ask that the witnesses respond in a timely manner.

With that, the subcommittee is adjourned.

[Whereupon, at 3:24 p.m., the subcommittee was adjourned.]

[Submissions for the Record follow:]

American Association of Retired Persons, AARP, Statement

September 21, 2011

The Honorable Wally Herger
Chairman
Ways and Means Health Subcommittee
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Pete Stark
Ranking Member
Ways and Means Health Subcommittee
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Herger and Ranking Member Stark:

On behalf of AARP's millions of members and the millions of older Americans and their families who depend upon the Medicare program, we thank you for holding this important hearing to discuss the expiring Medicare provider payment policies. While there are a number of Medicare provider issues that are set to expire by the end of the year, we would like to focus our remarks on Medicare physician payment policies; the physician fee schedule mental health add-on payment; the therapy caps exceptions process; and the qualified individuals (QI) program.

Medicare Physician Payment Policies

Protecting seniors' access to their Medicare doctors is one of AARP's top priorities. Our members -- whether they are Democrats, Republicans or Independents – tell us they want Congress to find a bipartisan, fiscally responsible solution that will keep doctors in the Medicare program. They are concerned that they will lose access to their doctors and future retirees won't be able to get the care they need.

Unless Congress acts by the end of the year, physicians who treat Medicare beneficiaries will face a 30 percent reduction in their Medicare reimbursements. Facing this constant uncertainty and dramatic cuts to their payments, more and more physicians are choosing to no longer take Medicare patients, which impacts beneficiaries' access to care.

Repeated short-term band-aid approaches for the broken physician payment system is not helpful. Rather, we urge Congress to enact legislation that changes payment policies to emphasize value over volume and improves outcomes and the quality of care for Medicare beneficiaries.

As Congress moves forward in developing an improved physician payment system, it is important to remember that Medicare beneficiaries' premiums and cost-sharing are directly tied to Part B program costs. Today, older people, on average, already spend nearly 20 percent of their income on health care. Imposing additional cost-sharing requirements on seniors will likely result in many more beneficiaries finding it difficult to pay for the care they need.

Physician Fee Schedule Mental Health Add-On Payment

One in four older Americans experience some form of mental disorder. According to a 2006 Institute of Medicine report, mental health disorders seldom occur in isolation and also tend to accompany a substantial number of general medical illnesses, making them difficult to detect. Two-thirds of older adults with mental health problems do not receive the treatment that they need.

Unfortunately, Medicare does not provide parity in its mental health coverage. In addition, the Centers for Medicare & Medicaid Services (CMS) recently reduced Medicare Part B reimbursement for certain mental health services. Thus far these cuts have been averted by legislation that provides and extends a five percent add-on payment for 24 psychiatry current procedural terminology (CPT) codes, which helps to ensure that Medicare beneficiaries have continued access to mental health professionals.

We are concerned that allowing the mental health add-on payment to expire will negatively impact Medicare beneficiaries, particularly those in rural areas where mental health services may be limited. Therefore, we urge Congress to renew the mental health add-on payment.

Therapy Caps Exceptions Process

Under current law, beneficiaries are subject to an annual limit ($1,860 in 2010) for all outpatient therapy services provided by non-hospital providers. Over the years, Congress has either prevented the caps from being implemented or, more recently, established an exceptions process where Medicare beneficiaries could be granted an extension and receive unlimited medically necessary therapy services. Unfortunately these exception provisions are set to expire at the end of the year.

If Congress fails to extend the exceptions process, Medicare beneficiaries who require medically necessary physical or speech therapy will have limited Medicare coverage for those much-needed services. Beneficiaries who exhaust this limited coverage will have to pay out-of-pocket for these services. As a result, many may forgo treatment, thus negatively impacting their health care.

AARP strongly supports extending the therapy cap exceptions process so that Medicare beneficiaries can continue to receive coverage for medically necessary physical and speech therapy services.

Qualifying Individual (QI) Program

The Qualifying Individual (QI) program provides funds to states to pay the Medicare Part B premiums for low-income Medicare beneficiaries with incomes between 120 percent and 135 percent of poverty. The QI program is capped and allocated to states as grants. As a result, participation in this much-needed program is often offered on a first-come, first-served basis until the yearly funds have been exhausted.

Hundreds of thousands of low-income Americans rely on the QI program in order to help defray their health care costs. Without this valuable program, these individuals would be more likely to forgo their care due to cost considerations and thus would end up costing the Medicare and Medicaid programs more in the long run.

AARP has long urged Congress to make the QI Program permanent. Absent that, we again encourage Congress to extend the QI program.

Conclusion

Over 47 million older and disabled Americans depend on Medicare today. AARP is committed to working with both sides of the aisle to ensure Congress passes legislation to address these expiring Medicare payment policies. If you have any questions, please feel free to call me or have your staff contact Anna Schwamlein Howard on our Government Affairs staff at 202-434-3770.

Sincerely,

Joyce A. Rogers
Senior Vice President
Government Affairs

American Clinical Laboratory Association, ACLA, Statement

American
Clinical Laboratory
Association

Statement of the
American Clinical Laboratory Association
to the Subcommittee on Health of the U.S. House Committee on Ways and Means
Expiring Medicare Provider Payment Policies
September 21, 2011

The American Clinical Laboratory Association (ACLA) congratulates Chairman Herger and the Subcommittee on Health for holding this hearing on expiring Medicare provider payment policies. ACLA represents clinical laboratories throughout the country, including local, regional, and national laboratories. ACLA member companies provide clinical diagnostic laboratory services to Medicare beneficiaries receiving services in physician offices, hospitals, nursing homes and many other settings. Our comments today address the technical component (TC) of physician pathology services provided to hospital inpatients and outpatients.

Since the beginning of the Medicare program, independent laboratories have been allowed to bill Medicare directly for both the technical component and the professional component (PC) of physician pathology services provided to hospital inpatients and outpatients. Technical component services include things such as specimen processing and slide preparation while professional services involve a pathologist's interpretation of the specimen. These physician services are vital to the operation of a successful surgical service in a hospital and include pathological examination of tissue removed during surgery, such as tumors, inflammatory tissue and biopsies, to determine whether and what disease is present.

Over the years many hospitals have chosen to have physician pathology services provided by independent laboratories for a variety of reasons. Some hospitals lack the surgical volume that would support an in-house pathology practice. Other hospitals choose to send specimens out because the independent laboratory, by taking in referrals from multiple sites, can provide more sophisticated diagnostic techniques for a wider range of cases than a single hospital can afford for its patients alone.

Since the beginning of 2001, Congress – through a "grandfather" exemption - has acted to limit implementation of a harmful CMS regulation that would eliminate Medicare payments to independent laboratories for surgical pathology technical component services provided to hospital patients. This "grandfather" applies to services delivered to any hospital that has used an independent laboratory for TC services as of July 22, 1999. Over time, Congress has reaffirmed this policy repeatedly. A permanent solution, however, is necessary to ensure uninterrupted access for Medicare beneficiaries to these critical health care services. Representative Geoff Davis (KY) introduced legislation in early July that would make permanent the current "grandfather" provision allowing independent laboratories to bill Medicare for the technical component of surgical pathology services for hospital patients. The bill, the Physician Pathology Services Continuity Act of 2011, HR 2461, is co-sponsored by Rep. Mike Ross (AR). We urge Congress to take up and pass this legislation.

Again, ACLA applauds Chairman Herger and the entire Subcommittee on Health for holding this important hearing. ACLA looks forward to continuing to work with the Committee on addressing the need for a permanent solution to the TC Grandfather for physician pathology services.

1100 New York Ave., N.W. • Suite 725 West • Washington, DC 20005 • (202) 637-9466

American Occupational Therapy Association. Statement

Occupational Therapy: Living Life To Its Fullest®

Via Online submission

STATEMENT FOR THE RECORD
HEALTH SUBCOMMITTEE OF THE HOUSE WAYS AND MEANS COMMITTEE:
Hearing on Expiring Medicare Payment Policies
September 21, 2011

Chairman Herger and Distinguished Members of the Health Subcommittee of the House Ways and Means Committee:

The American Occupational Therapy Association (AOTA), the national professional association representing more than 140,000 occupational therapists, occupational therapy assistants and occupational therapy students, across the country, submits this testimony regarding Medicare payment policies that are set to expire at the end of the 2011 calendar year, specifically the exceptions process for the Medicare Part B outpatient therapy caps. AOTA applauds the Committees' commitment to addressing these policies before the end of the year. The "therapy cap" policy sets a harmful and arbitrary annual cap on beneficiary access to essential health and rehabilitation services. Allowing implementation of the therapy caps will negatively affect patient access to critical services while adversely affecting rehabilitation outcomes, beneficiary quality of life, and long term health care and long term care costs. This is not a provider issue; this is a patient access issue that needs to be addressed to insure that our most vulnerable beneficiaries have appropriate access to the full spectrum of medically necessary and essential services including occupational therapy.

Occupational therapy is a patient-centered health, wellness, rehabilitation and habilitation profession dedicated to helping individuals gain, regain, and keep skills that are critical to optimal functional participation in everyday life activities. Occupational therapy services are provided for the purpose of promoting health and wellness to those who have or are at risk for developing or have an injury, illness, disease, disorder, condition, disability, activity limitation, functional limitation, or participation restriction. Occupational therapy addresses the physical, cognitive, psychosocial, sensory and other aspects of functional performance in a variety of contexts and settings to help people achieve a meaningful and rewarding quality of life.

4720 Montgomery Lane
Bethesda, MD 20814-1220
301-652-2682
301-652-7711 fax
800-377-8555 TDD
www.aota.org

Occupational therapy practitioners provide critical, cost-effective services to Medicare Part B recipients, focused on function, performance, self-care and full participation in their daily lives. Occupational therapy interventions help individuals to remain in their homes and communities while maintaining a high quality of life. An arbitrary cap on these services will yield a burden for Medicare, as beneficiaries will delay or decline treatments necessary to achieving maximum levels of independence, function and productivity, have more health problems and use more health care resources.

Without an exceptions process or other viable alternative in place beneficiaries will not have sufficient access to medically necessary services. The cap will have a negative effect on beneficiaries in need of rehabilitation services with a particularly severe impact on vulnerable populations including older, chronically ill beneficiaries Lack of a strong exceptions process will yield a decline in health status which can be expected to contribute to a rise in costs to Medicare and Medicaid as more beneficiaries will seek admissions to more costly facilities or will require visits to additional providers to address their increasing unaddressed health care needs.

BACKGROUND OF THE OUTPATIENT THERAPY CAPS

The Medicare Part B Outpatient therapy caps were originally established as part of the Balanced Budget Act of 1997. At that time Congress authorized an arbitrary $1500 cap on outpatient therapy services in private practice setting, physician offices, skilled nursing facilities (Part B), comprehensive outpatient rehabilitation facilities and rehabilitation agencies. The therapy caps were originally intended to be a temporary measure until the Center for Medicare and Medicaid Services (CMS) designed an alternative methodology for payment and assuring appropriate utilization to be considered by Congress.

Congress has consistently recognized the need to prevent implementation of the therapy caps, passing extensions of the exceptions process on five separate occasions since 2005. The current extension of the exceptions process was part of the Medicare Extenders Act of 2010 and runs until December 31, 2011.

AOTA believes a strong Medicare Part B program is a critical part of our overall health care system and is essential to assuring optimum and cost effective health for our nation's seniors and individuals with disabilities. The policies established by Medicare have a significant impact on payment policies throughout the health care system including private payers, Medicaid, and workers compensation.

THERAPY CAP ALTERNATIVES

As part of the 2010 Medicare Physician Fee Schedule Proposed Rule CMS solicited comments on three short-term options (or combinations thereof) set forth by the agency for discussion as alternatives to the cap on Medicare Part B outpatient occupational therapy services and on outpatient physical therapy and speech-language pathology services. In AOTA's view, portions of the three options could ultimately be part of a viable alternative to the therapy cap; however, as acknowledged by CMS in the preamble, at present there is insufficient or limited data from which to develop a rational alternative payment system at this time. None of the options presented provide a sufficient level of detail for AOTA to fully support any one option or combination of options at this time. AOTA in its comments stressed that any new system must be developed with the appropriate data; some of this data is not currently collected in the system but must be in order to develop a valid alternative.

AOTA staff and volunteer expert members will continue to work with CMS and CMS contractors on the short and long term alternatives to the therapy caps. AOTA is open to considering any alternatives or combination of alternatives that can help control costs while maintaining beneficiary access to the full panoply of necessary and essential care including occupational therapy. The focus of possible alternatives needs to prioritize the provision of high quality, cost effective care based on the judgment, and expertise of qualified health care practitioners and not on an arbitrary cap based solely on cutting costs.

In conjunction with efforts to repeal the cap, AOTA continues to work on the possibility of achieving greater accuracy and savings through changes to the current payment and coding system but urges the Committee to use extreme caution when considering any significant changes to the current system without appropriate planning and implementation. Changes to the current payment and/or coding system must be crafted in such a way as to insure there remains appropriate resources to achieve optimum outcomes which save long term costs for beneficiaries.

In particular, occupational therapy must be treated as the separate benefit it is and paid for as a distinct benefit. Any new payment and/or coding system can not be fashioned like the extremely problematic Multiple Procedure Payment Reduction Policy (MPPR). The MPPR policy fails to recognize the distinction between occupational therapy, physical therapy, and speech language pathology. This distinction needs to be recognized in any new payment and/or coding system to ensure beneficiaries adequate access to all appropriate skilled therapy providers. Medicare law does not currently authorize payment for a broad rehabilitation category; it authorizes payments separately for occupational therapy and physical therapy including speech language pathology services. Any new policy needs to continue this distinct recognition.

AOTA recognizes the need to find a long term solution but does not think the Committee should dismiss the concept of the exceptions process completely. The original intent of the exceptions process as instituted by Congress was to help address perceived overutilization and control costs while providing appropriate and effective care. It was initially considered a potential long term solution for the therapy caps issue. AOTA would support a narrowing of the current exceptions process with more stringent oversight and accountability that would still allow beneficiary access to essential care. Such a permanent extension of a narrowed exceptions process could be a viable long term solution to the therapy caps.

We encourage the Committee to work with the professional associations, consumer advocacy organizations and CMS to refine the exceptions process in such a way that would ensure patient access to covered necessary and essential services beyond an arbitrary cap while also reducing the overall cost to Medicare. A system that ensures beneficiaries are not denied access to medically necessary care is critical to achieving positive and ultimately cost effective long-term solutions. It is critical that treatment decisions are not taken away from patients and their qualified health care providers.

In closing, AOTA is ready to work with the Committee to identify long term solutions for the therapy caps that control costs while maintaining the quality of care. AOTA would once again like to thank the Committee for their work on this critical issue and historic bi-partisan support for acting to avoid implementation of the therapy caps on Medicare beneficiaries. AOTA encourages action to address the caps prior to the deadline for their implementation on January 1, 2011.

Thank you for your time and consideration regarding this critical matter. Please feel free to contact AOTA with any question or concerns regarding this or any other issue.

American Psychological Association Practice Organization, Statement

TESTIMONY OF THE
AMERICAN PSYCHOLOGICAL ASSOCIATION PRACTICE ORGANIZATION

Marilyn S. Richmond, J.D.
Assistant Executive Director for Government Relations

At a hearing of the
Ways & Means Subcommittee on Health
U.S. House of Representatives

September 21, 2011

"Expiring Medicare Provider Payment Policies"

The American Psychological Association Practice Organization is pleased to submit this testimony for your September 21 hearing on "Expiring Medicare Provider Payment Policies." We are a companion organization to the American Psychological Association that is devoted exclusively to representing the professional interests of practicing psychologists in all settings through a wide range of activities involving legislators and other policy makers, the legal system, purchasers and consumers of health care services and the health care marketplace.

To ensure the viability of the Medicare outpatient mental health benefit, we respectfully request your consideration and support of legislation that would extend through 2012 the law that restored cuts to Part B mental health services made by the Centers for Medicare & Medicaid Services in 2007.

Mental Health Extender. Through the Medicare Improvements for Patients and Providers Act of 2008, Congress partially restored the cuts made to psychotherapy reimbursement by the Centers for Medicare & Medicaid Services (CMS) "Five-Year Review" from July 1, 2008 through 2009. This 5% restoration of a cut which was actually 7% has come to be known in the Medicare statute as the "mental health add-on."

Two subsequent laws then extended the restoration through December 2011. The Patient Protection and Affordable Care Act, passed March 2010, extended the money from January

through December 2010. Following that, the Medicare and Medicaid Extenders Act of 2010, passed in December 2010, extended the money from January through December 2011.

The valuation of psychotherapy codes in the 2011 Five Year Review has been delayed into 2012. Congress should pass new legislation to extend payments through 2012, until the current Five Year Review is completed.

2006 Five Year Review. CMS cut by 7% Medicare part B reimbursement for psychologists and social workers effective January 1, 2007 under the Five Year Review (71 Fed. Reg. 37170). Under the Five Year Review rule, CMS increased payments for physician evaluation and management (E&M) codes, raising Medicare costs by $4.5 billion. Required by law to keep its costs budget neutral, CMS offset the higher E&M payments by reducing the work relative value units (RVUs) for all Medicare services.

Mental health and psychological testing services were hardest hit by the Five Year Review cut since reimbursement values for these services are heavily weighted by work RVUs. E&M services are important, but E&M payments should not be increased at the sacrifice of Medicare mental health services. Psychologists and social workers are not eligible for E&M reimbursement and should not shoulder the burden for the increase in physician E&M payments.

Effect on Beneficiaries. Extending psychologist payments cut by the Five Year Review is crucial to protecting access to Medicare mental health services. Psychologists and social workers provide almost all of the Medicare psychotherapy and testing services, but, speaking for psychology, many have indicated that they may have to reduce their caseloads or leave Medicare if they are faced with these reimbursement cuts. Congress, by its restoration of psychotherapy reimbursement, accepted our argument that many senior citizens could lose access to these services. It is important to point out that the restoration applies to the psychotherapy codes, thus all Medicare-authorized providers (psychologists, clinical social workers and psychiatrists) and their Medicare patients have benefited from it.

In a 2008 survey by the American Psychological Association, 11% of psychologists reported that they have dropped out of Medicare participation and a primary reason cited was low reimbursement rates. We estimate that 3,080 psychologists who once participated in Medicare have left the program.

The cost of protecting mental health services through this extender is very low, increasing costs by only $30 million per year, according to actuary Ron Bachman, FAAA, of Healthcare Visions, who is affiliated with the Center for Health Transformation.

Cut By MEI Rebasing. Later in 2011 a technical advisory panel in the Office of the CMS Actuary will be asked to examine the effect of a 4% cut to Medicare part B reimbursement for psychologists due to "rebasing" of the Medicare Economic Index (MEI). In the 2011 fee schedule, CMS used more recent survey data that showed practice expense and malpractice became a larger share of the payment formula while provider's time became smaller. This increased payments for some services, particularly of professionals who utilize expensive technology.

As in the Five Year Review, due to budget neutrality requirements, CMS reduced other reimbursement work values, which hit services of psychologists and social workers the hardest because they are typically provided at lower cost and lower overhead. Since January 1, 2011 our members have been receiving 4% lower reimbursement for all of their services, not just the psychotherapy which was cut by the Five Year Review.

These cuts are not related to the Sustainable Growth Rate. Psychologists were saved from a second and even more devastating reduction when Congressional action halted the projected 25% SGR cut through December 31, 2011. A larger SGR cut is scheduled for January 1, 2012. Ultimately Congress must replace the flawed SGR formula with one that responsibly and permanently addresses provider payments.

We appreciate the Subcommittee's interest in these important reimbursement matters.

American Speech Language Hearing Association, Statement

AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

September 28, 2011

RE: Statement of the American Speech-Language-Hearing Association Regarding the Hearing on Expiring Medicare Provider Payment Policies

Dear Chairman Herger, Ranking Member Stark, and Members of the Health Subcommittee of the House Ways and Means Committee:

The American Speech-Language-Hearing Association (ASHA) appreciates the opportunity to provide this statement for the Committee record related to the September 21, 2011, hearing on expiring Medicare Provider Payment Policies. ASHA is the professional and scientific association representing 145,000 speech-language pathologists, audiologists, and speech-language and hearing scientists. Our comments will focus on the, more than a decade long, effort to repeal the therapy caps and replace it with a system that allows appropriate beneficiary access to medically necessary speech-language pathology and physical and occupational therapy. To that end, we request that Congress extend the therapy cap exceptions process through calendar year 2014, and work with stakeholder groups in the development of a reformed payment policy.

The therapy cap policy is flawed, as it sets an arbitrary cap on beneficiary expenditures that has no basis on the practitioner's clinical judgment on the need for therapy. The caps were developed without the review of patient needs and other relevant data, such as patient outcomes. The policy was meant as a stop gap measure to control costs as the agency establish revised coverage policies based on patient characteristics. In creating the caps, Congress specifically directed the Secretary of Health and Human Services to develop recommendations, as referenced in the following citation:

> *2) REPORT- By not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that includes recommendations on the establishment of a revised coverage policy of outpatient physical therapy services and outpatient occupational therapy services under the Social Security Act based on classification of individuals by diagnostic category and prior use of services, in both inpatient and outpatient settings, in place of the uniform dollar limitations specified in section 1833(g) of such Act, as amended by paragraph (1). The recommendations shall include how such a system of durational limits by diagnostic category might be implemented in a budget-neutral manner.*

Over the past decade, under both Republican and Democratic leadership, Congress either extended a moratorium on the implementation of the therapy caps or more recently supported continued extensions of the therapy cap exceptions process. In doing so, Congress recognizes that placing arbitrary limits on a patient's access to outpatient speech, physical, and occupational therapy is not in the best interest of the patient.

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Should this Committee consider alternative payment reforms for outpatient therapy services, ASHA requests that any alternative be based on patient need, risk adjusted to ensure that the most fragile and ill patients receive appropriate services and take into account patient outcomes. Additionally, in order to develop appropriate payment for outpatient therapy services, both Congress and CMS must recognize and maintain each therapy service as a unique and distinct benefit and ensure that coverage guidelines are consistent with professional standards of best practice and clinical decision-making for each distinct therapy service.

Speech Language Pathology Services Under Medicare

Although an important intervention for many Medicare beneficiaries, speech-language pathology services account for a very small percentage of overall Medicare Part B spending. In terms of outpatient therapy expenditures, speech-language pathology services only account for approximately 7%. According to the Centers for Medicare and Medicaid Services, in 2008 speech-language pathologists served approximately 478,000 beneficiaries and accounted for $336 million in Medicare outpatient therapy expenditures. The average patient received $702 in services. CMS also reported that when beneficiaries received both physical therapy and speech-language pathology services, 15.3% exceeded the cap.

Speech-language pathologists (SLPs) provide critical services to Medicare beneficiaries in treating complex neurological conditions that may be caused by a stroke, Parkinson's disease or other serious condition. Speech-language pathologists not only work on speech and communication issues, but also work with patients on cognition and swallowing difficulties (dysphagia). In a recent CMS report, dysphagia services was ranked as one of the most frequently administered therapies that speech-language pathologists provide to the Medicare population. Failure to treat dysphagia can lead to malnutrition, dehydration or aspiration pneumonia, both of which extend a hospital stay or require re-hospitalization, thereby increasing costs to the Medicare program.

Under the therapy caps and absent an exceptions process, a beneficiary must divide limited therapy resources between physical therapy and speech-language pathology services. Due to a quirk in the statute, physical therapy and speech-language pathology services are combined under one cap while another cap was established for outpatient occupational therapy services. Due to the nature of the interventions provided by speech-language pathologists and physical therapists, physical therapy is often the first therapy received by a beneficiary. Where more intense intervention is required, it is not usual for the patient to exceed the cap before even receiving speech-language pathology services.

Having to choose between which services (i.e., physical therapy or speech-language pathology) a beneficiary will receive puts the patient at serious risk. Cognitive and communication deficiencies can affect a beneficiary's ability to communicate needs to their caregivers, increase physical therapy due to inability to follow directions, and could lead to potential safety issues. Additionally, failure to appropriately identify and provide services to individuals with communication and cognitive deficits may lead to a failure in providing appropriate interventions, therefore, placing the patient at risk for further medical complications. This may result in higher costs to the Medicare program.

Speech-Language Pathology Reimbursement Under Medicare

Unlike physical therapy and occupational therapy reimbursement, which is based on time-based codes, SLPs bill their services using CPT codes that are non-timed procedure based codes. Speech-language pathologists have specific codes designated for treatment and evaluation. These codes may only be billed once daily regardless of the severity of the patient or the type of intervention provided by the practitioner. With the exception of dysphagia evaluations and evaluations for speech generating devices, SLPs do not use high tech equipment that differentiates the cost of the session. Additionally, CMS regulations do not allow the use of assistants for the provision of speech-language pathology services.

Additionally, SLPs are currently eligible to participate in the Physician Quality Reporting System (PQRS) by reporting functional outcomes measures associated with ASHA's National Outcomes Measurement System (NOMS). NOMS is a data collection system developed to illustrate the value of speech-language pathology and audiology services provided to adults with communication and swallowing disorders. Through the use of NOMS, the association is able to provide its members the needed tools to demonstrate progress and gather data that addresses the challenging questions posed by policy makers, third party payers, and administrators.

Alternatives

Over the past decade, CMS has conducted many studies on patient characteristics and the need for therapy. Most recently it is collecting data through its DOPTA project. Unfortunately, even with data collection efforts underway, there has been no real movement by CMS to develop and test alternative payment systems. Absent this leadership, stakeholders such as the American Speech-Language-Hearing Association and the American Physical Therapy Association (APTA) have moved forward in the development of reformed payment systems for their unique constituencies. However, these systems need further development and would need to be tested to ensure that any new payment system does not adversely affect beneficiary access to outpatient therapy services.

As part of the testimony before the Committee, the American Physical Therapy Association proposed the development of a new system for single visit payment for **physical therapy services** based on the severity and intensity of the service. We support APTA's efforts to refine its coding system, and believe that this will enhance the accuracy of payment for **physical therapy services** and prevent inappropriate billing by non-qualified providers. We, however, do not support APTA's reformed payment system for speech-language pathology services. Research conducted on the data derived from ASHA's NOMS system has indicated that factors, such as severity and intensity of services, do not accurately reflect the cost of a speech-language pathology sessions, but do affect the length of time to achieve a treatment goal.

ASHA is currently seeking to engage in discussions with CMS to initiate a pilot program to investigate the feasibility and appropriateness of an episode-based payment system for speech-language pathology services. ASHA's proposed pilot involves moving from a per session

reimbursement model to a per episode model based on the extensive data collected through ASHA's National Outcomes Measurement System (over 200,000 patient episodes). Using NOMS data, patient groupings have been identified based on their severity and complexity and the number of hours of treatment required achieving progress. These groupings could translate to payment groups based on the cost of the number of hours of treatment each group received. Because the distribution of patients into different groups can be predicted from NOMS data, CMS could further anticipate the annual cost of the Part B speech therapy benefit.

Additionally, ASHA supports efforts to refine the exceptions process and encourages the Committee to work with Congress in identifying ways to implement a cost-effective exceptions process that ensures patients who need services beyond the therapy cap receive those services and minimizes the administrative burden on CMS and providers.

ASHA also supports program integrity efforts aimed at reducing fraud and abuse in the Medicare system. To that end, we are supportive of the concept behind S. 1551, which would require smart cards for both providers and beneficiaries.

Thank you for the opportunity to share our views with the Committee. Should you have any questions regarding our statement, please contact Ingrida Lusis, ASHA's director of federal and political advocacy, by e-mail at ilusis@asha.org or by phone at 202-624-5951.

Sincerely,

Paul R. Rao, PhD, CCC, CPHQ, FACHE
2011 ASHA President

Arizona Hospital and Healthcare Association, Statement

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.

Debbie Johnston

Vice President of Advocacy,

Arizona Hospital and Healthcare Association

Center for Fiscal Equity, Statement

Comments for the Record

House Committee on Ways and Means

Subcommittee on Health

Hearing: Expiring Medicare Provider Payment Policies

September 21, 2011, 2:00 PM

by Michael G. Bindner

The Center for Fiscal Equity

Chairman Herger and Ranking Member Stark, thank you for the opportunity to submit my comments on this topic. This topic is key to the question of the affordability of health care entitlements. It is useful to compare the impact of how provider limits have been dealt with between the Medicare and Medicaid programs.

Medicare provider cuts under current law have been suspended for over a decade, the consequence of which is adequate care. By way of comparison, Medicaid provider cuts have been strictly enforced, which has caused most providers to no longer see Medicaid patients, driving them to hospital emergency rooms and free clinics with long waiting periods to get care.

The Affordable Care Act works toward increasing funds for Medicaid providers, which is necessary to get people out of emergency rooms. The same act, however, counted on assuming that Medicare provider cuts would be implemented – a heroic assumption – in order to pass according to budget rules. Now that the Act is passed, however, the fiction that current law will be maintained can be dispensed with.

Parity between Medicare and Medicaid is desirable, although without mandatory sick leave, it will not keep poor people from having to use emergency room care, although it will benefit nursing home patients who will be able to see a doctor without hospitalization.

Separating Medicaid into a program for retirees and a program for the non-retired working and non-working poor will allow the retiree program to be fully federalized and managed with Medicare, rather than the separate management that occurs now under CMMS, which is part of the problem. That simple step will add clarity to this issue.

There are many ways of achieving parity, however great care must be used so that these don't constitute a race to the bottom. Cost shifting should not be used as a substitute for cost saving, especially if such shifting violates the tenants of social insurance.

The whole purpose of social insurance is to prevent the imposition of unearned costs and payment of unearned benefits by not only the beneficiaries, but also their families. Cuts which cause patients to pick up the slack favor richer patients, richer children and grand children, patients with larger families and families whose parents and grandparents are already deceased, given that the alternative is higher taxes on each working member. Such cuts would be an undue burden on poorer retirees without savings, poor families, small families with fewer children or with surviving parents, grandparents and (to add insult to injury) in-laws.

Recent history shows what happens when benefit levels are cut too drastically. Prior to the passage of Medicare Part D, provider cuts did take place in Medicare Advantage (as they have recently). Utilization went down until the act made providers whole and went a bit too far the other way by adding bonuses (which were reversed in the Affordable Care Act). There is a middle ground and the Subcommittee's job is to find it.

Resorting to premium support, along with the repeal of the ACA, have been suggested to save costs. Without the ACA pre-existing condition reforms, mandates and insurance exchanges, however, premium support will not work because people will have no assurance of affordable coverage. This, of course, assumes that private insurance survives the imposition of pre-existing condition reforms. If it does not, the question of both premium support and the adequacy of provider payments is moot, since if private insurance fails the only alternatives are single-payer insurance and a pre-emptive repeal of mandates and protections in favor of a subsidized public option. The funding of either single-payer or a public option subsidy will dwarf the requirement to fund adequate provider payments in Medicare and Medicaid.

Resorting to single-payer catastrophic insurance with health savings accounts would not work as advertised, as health care is not a normal good. People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate – further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded.

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding).

We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so we will confine our remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The NBRT can provide an incentive for cost savings if we allow employers to offer services privately to both employees and retirees in exchange for a substantial tax benefit, either by providing insurance or hiring health care workers directly and building their own facilities. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets.

Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

The Center calculates an NBRT rate of 27% before offsets for the Child Tax Credit and Health Insurance Exclusion, or 33% after the exclusions are included. This is a "balanced budget" rate. It could be set lower if the spending categories funded receive a supplement from income taxes.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Contact Sheet

Michael Bindner
Center for Fiscal Equity
4 Canterbury Square, Suite 302
Alexandria, Virginia 22304
571-334-8771
fiscalequity@verizon.net

Subcommittee on Health
Hearing: Expiring Medicare Provider Payment Policies
September 21, 2011, 2:00 PM

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.

College of American Pathologists, CAP, Statement

Statement Submitted

By

The College of American Pathologists

Hearing to Examine Expiring Medicare Provider Payment Provisions

Subcommittee on Health

Committee on Ways and Means
U.S. House of Representatives

September 21, 2011

College of American Pathologists

Division of Advocacy

1350 I Street, NW, Suite 590

Washington, DC 20005

www.cap.org

INTRODUCTION

The College of American Pathologists (CAP), representing 17,000 pathologists who practice clinical and/or anatomic pathology, appreciates the opportunity to submit comments to the House Ways and Means Subcommittee on Health regarding the extension of a "grandfather" provision for crucial physician pathology services under Medicare. The CAP is the world's largest association composed exclusively of board-certified pathologists and is the worldwide leader in laboratory quality assurance. CAP members practice their specialty in community hospitals, independent laboratories, academic medical centers and federal and state health facilities. More than 7,000 laboratories are accredited by the CAP, and approximately 23,000 laboratories are enrolled in the College's proficiency testing programs.

The CAP recognizes the difficult task of deficit reduction facing the Congress and the need to improve health care quality while curbing costs. Pathologists, with their expertise in diagnostic testing, are doing their part to deliver the most targeted and effective treatments for patients. Through their understanding of the basis of disease, they can help improve the quality, efficacy, accuracy and safety of health care delivery.

POSITION ON TECHNICAL COMPONENT (TC) "GRANDFATHER" FOR PATHOLOGY SERVICES

The CAP strongly supports a permanent extension of the "grandfather" provision contained in bipartisan legislation H.R. 2461, *the Physician Pathology Services Continuity Act of 2011,* introduced by Representatives Geoff Davis (R-KY) and Mike Ross (D-AR). This legislation allows independent laboratories, under certain conditions, to bill Medicare directly for the technical component (TC) of anatomic pathology services, commonly referred to as pathology services, provided to hospital patients. Unless Congress acts this year, the "grandfather" will expire, adversely impacting hospitals, independent laboratories and the patients they serve.

BACKGROUND

Since the beginning of the Medicare program, independent laboratories have been allowed to bill Medicare directly for both the TC and professional component (PC) of pathology services provided to hospital patients. Pathology services are physician services under Part B. They are essential to surgical services in a hospital. They include pathologist examination of tissues removed during surgery, such as tumors, inflammatory tissue and biopsies, to determine whether and what disease is present. The TC of pathology services includes specimen processing and special preparation of tissue samples. The PC for these services involves pathologist interpretation of the specimen and diagnosis.

Over the years many hospitals have chosen to have these pathology services provided by independent laboratories for a variety of reasons. Some hospitals lack the surgical

volume to support an in-house pathology practice. This is particularly true in rural communities and small hospitals. Others have chosen to send specimens out because the independent laboratory, by taking in referrals from multiple sites, can provide more sophisticated diagnostic techniques for a wider range of cases than a single hospital can afford for it patients. Finally, in these arrangements, independent laboratories are often able to provide the services more efficiently given the economies of scale they generate.

In 2000, CMS implemented a new rule that eliminated Part B payment for the TC of pathology services provided by independent laboratories. This meant that hospitals that had been relying for decades on independent laboratories to provide these services would incur new costs. Hospitals were not given additional funds to pay for these services.

That same year, Congress provided legislative relief in the form of a "grandfather" provision for hospitals that were using independent laboratories for pathology services as of July 22, 1999 -- the date the first proposed rule change was published. Since then, Congress has consistently extended the "grandfather" with strong bipartisan support; most recently as part of *the Medicare and Medicaid Extenders Act of 2010*. Without Congressional action, the "grandfather" provision is set to expire at the end of this year.

It's important to note that "grandfathered" hospitals may utilize any independent laboratory for their TC pathology services. This allows for competition among laboratories for delivery of care, and allows hospitals to choose the laboratory that best meets their needs. Because the "grandfather" applies to a set universe of hospitals, there can be no unlimited growth going forward. Moreover, if the "grandfathered" had only been using an independent laboratory for certain situations or at particular times, those restrictions continue to apply.

IMPACT

The consequences of not extending the "grandfather" are severe. Hospitals, independent laboratories and patient care would suffer. Hospitals would not be able to absorb the additional costs for these TC pathology services. Yet, without these services, a hospital cannot offer surgical services to its patients. Approximately three-quarters of states in the country would be impacted. The burden would fall especially hard on smaller and rural hospitals. In fact, some hospitals may be unable to continue providing quality surgical services in local communities, requiring patients to travel far from their homes, families and their regular physicians in order to obtain needed procedures.

Many independent laboratories are small businesses. They face the same economic headwinds and cost pressures that other small businesses face. Without the "grandfather", these laboratories may be forced to cut back on testing services as well as investments in new technologies that benefit patients. Economies of scale would be lost. Worse still, jobs may be lost. A laboratory practice that can't meet its costs cannot endure indefinitely. Furthermore, providing services below cost can trigger compliance concerns for both parties. Providing Medicare services below cost is generally considered inducement or a kickback under federal law.

Finally, without the "grandfather," both hospitals and independent laboratories would have to establish new costly and administratively complex billing systems. Under direct billing, independent laboratories submit a single bill to Medicare for both TC and PC services. Without direct billing, laboratories would have to issue two bills – one to Medicare for the PC and another to the hospital for the TC, doubling billing requirements and costs. Hospitals would be required to set up systems to receive and account for these billings and TC costs and pay the laboratories once payment has been received from the hospitals' intermediaries – all at a time when providers are already struggling to keep pace with a myriad of Medicare regulations.

CONCLUSION

Health care providers are already being asked to do more with less. The "grandfather" is a fair, reasonable and effective response to ensure stability and continued patient access to vital pathology services. The CAP urges timely continuation of the TC "grandfather" and passage of H.R. 2461.

Federation of American Hospitals, Statement

Federation of American Hospitals
Statement for the Record

U.S. House of Representatives
Committee on Ways & Means
Subcommittee on Health

Hearing on Expiring Medicare Provider Payment Policies

Wednesday, September 21, 2011

1100 Longworth House Office Building

Federation of American Hospitals
Statement for the Record
Hearing on Expiring Medicare Provider Payment Policies
Ways & Means Subcommittee on Health
Wednesday, September 21, 2011

The Federation of American Hospitals (FAH) is pleased to submit the following statement for the record as the U.S. House of Representatives Ways and Means Health Subcommittee considers expiring Medicare provider payment provisions especially critical to our rural hospitals. The FAH is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include general community hospitals and teaching hospitals in urban and rural America as well as inpatient rehabilitation, long term acute care, psychiatric and cancer hospitals.

FAH appreciates the Committee's interest in the impact of these provisions on patients and providers alike. Rural hospitals are the health and economic backbone for communities across America, delivering vital health care to millions of Americans. They are often the sole source of comprehensive health care where they are located, and are typically the largest employer, and economic engine, in the communities they serve.

Especially in our current economic environment, rural hospitals face a wide array of financial difficulties and operational challenges which imperil their ability to continue to serve these areas in the manner that rural citizens expect and deserve. Chief among them is the steady erosion of public funding under Medicare and Medicaid. Extending targeted payment policies that are set to expire is critically important to bolster their fragile finances and help preserve these hospitals so they can continue to meet their mission.

The rural population served by community hospitals is typically older and poorer, which means that rural hospitals are forced to rely to a greater extent on Medicare and Medicaid funding, and are, therefore, especially vulnerable to cuts to these crucial sources of payment. This is particularly troubling because of the well-documented Medicare and Medicaid payment shortfalls. The Medicare Payment Advisory Commission (MedPAC) reports negative 4.9 percent overall Medicare margins for rural hospitals in 2009, the seventh consecutive year that Medicare payments fell below the cost of care. That number is expected to drop further in 2011. Medicaid payment shortfalls are even larger, while mounting state budget deficits are leading to lower payments at the same time that the struggling economy causes Medicaid caseloads to grow.

These payment pressures, combined with the challenges of chronic workforce shortages, relentless regulatory burdens that increase in size and scope, limited access to capital, and the difficulty of a small rural hospital to generate economies of scale, further threaten an already vulnerable, yet vital community asset.

While we welcome the Subcommittee's examination of certain expiring Medicare payment policies, we strongly urge their extension. Below, we discuss specific policies.

- **Low-Volume Hospital Payment Adjustment**

  This provision has its roots in a MedPAC recommendation. It recognizes the fact that rural facilities, which are typically small and more isolated, are handicapped in their ability to drive lower unit costs through greater economies of scale. This sliding-scale payment adjustment helps compensate for this competitive disadvantage.

- **Section 508 Wage Index Reclassification**

  Originally enacted as part of the Medicare Modernization Act, this provision addresses one of many flaws of the current wage index system, and enables certain hospitals to obtain a fair and equitable wage index adjustment that would otherwise be unavailable to them.

  The subject of geographic adjustments to Medicare payments generally, and the wage index in particular, is currently under broad review. Earlier this year, the Centers for Medicare and Medicaid Services (CMS) released a report by one of its contractors, Acumen, that introduced a novel approach to determining wage index adjustments. Later, in June, the Institute of Medicine (IOM) released a study, sponsored by CMS, recommending fundamental structural changes to the wage index methodology including data sources. The IOM expects to release two additional studies addressing geographic adjustments. Also, under the Affordable Care Act, Congress directed CMS to submit a report by the end of this year that includes a plan to reform the hospital wage index system and which takes into account reforms previously recommended by MedPAC.

  We look forward to the completion of these studies so that they can be fully evaluated by Congress in the context of comprehensive wage index reform. In the meantime, Section 508 provides an important avenue for hospitals to receive an appropriate wage index adjustment in a Medicare payment system that is structurally underfunded.

- **Outpatient Hold Harmless for Small Rural Hospitals**

  Since its inception in 2000, the Medicare outpatient prospective payment system (OPPS) has paid hospitals well below the cost of outpatient care. According to MedPAC, in 2009 the margin on Medicare outpatient services was negative 10.8 percent, about the same level it has been since 2003. This is particularly troubling for rural hospitals, as more of their services are provided in the outpatient setting, more services continue to migrate from inpatient to outpatient, and Medicare accounts for a greater percentage of revenue.

Recognizing this vulnerability, Congress has historically provided small rural hospitals with a safety net that partially bridges the gap between pre and post-OPPS payments. These hold-harmless payments have declined over time to 85 percent of the difference, so that even with this protection, Medicare outpatient payments to rural hospitals still fall substantially below the cost of care. As long as this payment shortfall exists, Congress should extend this important payment protection.

- **Medicare Dependent Hospital Program**

  As noted earlier, rural hospitals provide health care to communities that are typically older, and these rural facilities are often their chief source of hospital care. This provision is designed to provide an additional measure of protection for smaller rural hospitals serving a disproportionate Medicare caseload – greater than 60 percent. Because Medicare payments fall so far below the cost of care, and because these small rural hospitals have virtually no other revenue recourse to defray this substantial payment shortfall, Congress since 1987 has provided a modest supplemental payment to help ensure the survival of these hospitals and access to hospital care for seniors in rural communities. We urge Congress to continue this program and reassure seniors that the hospitals they depend on for care will be there when they need them.

- **Physician Pathology Services**

  Independent laboratories have long partnered with rural hospitals to provide essential pathology services for seniors receiving hospital care. In general, the laboratory is paid separately for these services under the Medicare physician fee schedule. In November 1999, however, CMS denied laboratories the ability to bill CMS directly for the technical component of pathology services provided to beneficiaries in a hospital setting, threatening to disrupt this longstanding arrangement and impose a new financial burden on rural hospitals. CMS asserted that the hospital DRG payment already bundled these costs into the payment, an assertion that rural hospitals dispute.

  In response, Congress, in 2000, grandfathered the longstanding practice, permitting independent laboratories with existing hospital arrangements to bill CMS directly for the technical payment component for pathology services provided to seniors receiving hospital care. Congress should continue this sensible solution.

Conclusion

FAH encourages the Members of the Subcommittee to continue their support for the fore mentioned payment policies so critical to rural hospitals. Furthermore, we stand ready to work with Congress to ensure continued access to quality health care for seniors.

Focus on Therapeutic Outcomes, Inc., Statement

FOTO

Interactive Health Analysis®
Patient Inquiry®

September 17, 2011

The Honorable Wally Herger
The Honorable Pete Stark
Subcommittee on Health
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Herger and Ranking Member Stark:

Focus On Therapeutic Outcomes, Inc., (FOTO) is pleased to submit this statement for the record pertaining to the hearing of the House Ways and Means Health Subcommittee on September 20 to examine expiring provisions of the Medicare payment system.

As the leading developer of quality and outcomes measurement systems for outpatient rehabilitation therapies, FOTO serves providers and facilities nationwide. For over eighteen years, FOTO has been developing, improving, perfecting and providing valid and reliable methods for the assessment of function in patients receiving outpatient physical and occupational therapy services. Using data gathered from over 3.900 clinical practice locations, FOTO has developed a robust database of over 3.1 million episodes of therapy and has advanced user-friendly, economical methods for collecting, analyzing and utilizing functional status measures.

Focus On Therapeutic Outcomes, Inc., comments on one issue in particular of relevance to the hearing; namely the Medicare Per Beneficiary Therapy Caps.

Medicare Therapy Caps
In January 2012 the arbitrary Medicare per beneficiary therapy caps will be fully imposed unless Congress acts to extend the current exceptions process or repeal the caps permanently. While the latter is by far the preference, at minimum the exceptions process must be extended to avoid unduly affecting those beneficiaries who are most in need.

Focus On Therapeutic Outcomes, Inc.
P.O. Box 11444 Knoxville, TN 37939
1.800.482.3686 t:865.450-9699 f:865.450.9484
www.fotoinc.com

Without congressional intervention, the therapy caps will once again arbitrarily end Medicare's coverage of outpatient physical therapy, occupational therapy, and speech-language pathology services once a beneficiary has received an artificial dollar amount of services ($1,870) of services in an entire calendar year. This set amount is without respect to a patient's condition or the need for services or the use of services at other times during a calendar year for either the same or a different condition.

It applies to Medicare beneficiaries in all outpatient health care settings with the exception of outpatient hospital departments. Beneficiaries who receive Part B rehabilitation services within a skilled nursing facility, a therapist's or physician's office, a home health agency, or a rehabilitation agency are subject to the arbitrary cap.

Some 14.5 percent[1] or 640,000 Medicare beneficiaries who receive outpatient rehabilitation services per year are estimated to exceed the existing statutory therapy cap if Congress does not extend the exceptions process. Once the limit has been reached, beneficiaries who require additional services are responsible for the total cost. Seniors and individuals with disabilities with the most significant rehabilitation needs will have to decide between foregoing necessary care, changing providers of care, or paying 100 percent of the cost out-of-pocket. Beneficiaries who experience stroke, hip fracture, Parkinson's disease, diabetes, arthritis or osteoporosis are most likely to be negatively affected by the therapy caps. Thus, beneficiaries with impairments and disabilities are adversely and unfairly impacted by this arbitrary payment policy.

FOTO urges Congress to extend the exceptions process for three years and direct the Centers for Medicare and Medicaid Services (CMS) to prepare an "alternative payment method" which was envisioned by the Balanced Budget Act of 1997. Specifically, Congress should direct CMS to utilize the exceptions process to incentivize the collection and submission of quality information (e.g., **functional outcomes data**) which could be used to describe the type and amount of care that is needed by specified patients or groups of patients. Legislative language that would operationalize this policy ("The DCS Exception") is appended to the end of this letter.

The arbitrary, per beneficiary annual therapy caps were authorized as part of the Balanced Budget Act of 1997. Since their scheduled implementation date of January 1, 1999, Congress has intervened numerous times to preempt this errant policy by placing a moratorium on the caps or, since 2005, extending a broad-based exceptions process. These caps were intended to be temporary until "an alternative payment method" could be developed. But such an alternative has not materialized in 14 years. **Yet, one is possible** if Congress and the Centers for Medicare and Medicaid Services (CMS) would commit to collecting the necessary descriptive data upon which such an alternative could be predicated.

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[1] Ciolek, DE, Wenke H. *Utilization Analysis: Characteristics of High Expenditure Users of Outpatient Therapy Services CY 2002.* Final Report to the Centers for Medicare and Medicaid Services. November 22, 2004

A limited (and targeted) extension of exceptions process for 2012, 2013, and 2014 combined with instructions to CMS to grant the therapy cap exception for care delivered to Medicare beneficiaries in any setting that is collecting and reporting functional outcomes data would result in a database containing sufficiently robust information to design the alternative payment method envisioned by the 1997 BBA. Most importantly, such a payment model would not be based on an arbitrary limit but rather on the amount and type of care needed to achieve the desired optimal outcome.

In the Physician Quality Reporting System (PQRS), CMS has recognized 7 outcomes measures that quantify change in risk-adjusted functional status of patients with certain impairments. These measures quantify various aspects of clinical quality including patient outcome, efficiency of care and patient experience of care; are functional in nature; are administratively nonburdensome for clinicians; and can be technically implemented within the capacity of the CMS infrastructure for data collection, analysis, and calculation of reporting and performance rates.

Moreover, these seven FOTO measures facilitate alignment of care with, other Medicare, Medicaid, and CHIP programs in furtherance of overarching healthcare goals. In particular, these measures have the propensity to align financial incentives with the implementation of care processes based on best practices and the achievement of better patient outcomes as recommended by the Institute of Medicine (IOM) in *Crossing the Quality Chasm.*

Ultimately, payment for rehabilitation therapy should be based on accurate risk-adjusted measures of function or quality for an episode of care. Using the above measures to collect outcomes data on patient care will enable Congress and CMS to rapidly and accurately develop such a payment system. In doing so, the therapy cap issue will be relegated to history.

On behalf of FOTO, thank you for your continued efforts to create a more stable, predictable and effective Medicare payment system. FOTO is eager to continue to work with the Committee, Congress and CMS to advance the above-identified concepts.

Sincerely,

Ben E. Johnston, Jr., PT
General Manager

ADDENDUM

Proposed Therapy Cap Alternative

Exceptions Process Based on Submission of Quality and Outcomes Data

"The DCS Exception"

(a) **BENEFICIARY CONDITION AND OUTCOMES DATA**

1. **In General.** – No later than January 1, 2012, the Secretary of Health and Human Services ("Secretary") shall in collaboration with national professional associations representing each therapy discipline (including physical therapy, speech-language pathology, and occupational therapy) and those associations that represent providers or suppliers who offer services to beneficiaries in need of such services implement an initiative to:
   (a) identify general and discipline-specific data elements regarding patient condition, including severity of condition,
   (b) develop general and discipline-specific patient assessment processes to collect such data,
   (c) identify and measure appropriate indicators, such as age, illness, severity and settings, that may be used in assessing appropriate payment for services, and
   (d) implement a data collection system ("DCS") using the above-referenced discipline-specific assessment tools that measure the quality and efficiency of therapy treatment.

2. **Sites.** --The Secretary shall ensure that the initiative includes a variety of geographic sites and practice settings including nursing facilities in which the therapy disciplines furnish services under Medicare Part B.

(b) **SERVICES NOT SUBJECT TO PER BENEFICIARY CAP**

1. In General. -- Any provider or supplier that furnishes outpatient therapy services to fee-for-service Medicare beneficiaries or outpatient rehabilitation services provided in a SNF under consolidated billing provision and submits claims to the Medicare program for such services, may voluntarily agree to participate in the DCS by submitting data on quality measures or patient outcomes to the Secretary.

2. Beneficiaries receiving treatment from a person or entity participating in the data collection initiative described in this paragraph shall not be subject to financial limitations under section 1833(g)(2) of the Social Security Act (42 U.S.C.1385l(g)(2)).

(c) **REPORTS.** -- The Secretary shall report to the Congress on (a) the adequacy of the assessment processes in reflecting the quality and efficiency of therapy treatment, (b) identify or recommend alternative data elements and assessment processes that would reflect the quality and efficiency of therapy treatment, and (c) payment methods based on beneficiary need and effectiveness of rehabilitation as alternatives to the beneficiary therapy caps. The Secretary shall submit an interim report to the appropriate committees of the Congress no later than October 1, 2012, and a final report to such committees no later than April 1, 2013.

Gundersen Lutheran, Statement

October 4, 2011

The Honorable Wally Herger
Chairman, House of Representative Ways and Means Subcommittee on Health
1102 Longworth House Office Building
Washington D.C. 20515

Re: Expiring Medicare Provider Payment Policies

Dear Chairman Herger:

On behalf of Gundersen Lutheran, we appreciate the opportunity to comment on several key policies enacted by Congress crucial for providing access to care in rural areas of our country. On behalf of Gundersen Lutheran, we support continuing Medicare physician payment policies impacting the Physician Work Index and Practice Expense Index along with ensuring rural areas have continued access to emergency transportation services.

About Gundersen Lutheran

Headquartered in La Crosse, Wisconsin, Gundersen Lutheran Health System provides quality health services to patients at its hospital and clinics throughout predominantly rural areas in western Wisconsin, southeastern Minnesota and northeastern Iowa. Gundersen Lutheran is an integrated, major tertiary teaching hospital, providing a broad range of emergency, specialty and primary care services and consistently ranked in the upper 5% of hospitals nationwide.

Geographic Practice Cost Index

Research demonstrates wide variation in Medicare per beneficiary spending throughout geographic regions across the United States. Currently, the Geographic Practice Cost Index (GPCI) formula includes various components used to calculate overall payment to physicians, including indices of work, practice expense, and malpractice insurance costs. Currently, this formula is being evaluated through a series of studies by the Institute of Medicine (IOM), which is releasing recommended guidance and changes to the existing Medicare fee-for-service physician payment formula. The overarching goal of the IOM studies on geographic variation is to find ways to move reimbursement away from fee-for-service to incorporate cost and quality metrics. However, while the IOM is continuing their studies to implement value in healthcare payments, a gap exists between their final recommendations, and key policies historically enacted by Congress prior to and including the Affordable Care Act (ACA) that assist rural and low Medicare reimbursed areas.

Physician Work Index Floor

The Physician Work (PW) index is a component of the physician payment formula designed to account for costs relative to labor in a particular Medicare payment locality. Currently, the PW index is devised from Bureau of Labor (BLS) Occupation Employment Statistics (OES) from 2006-2008 to derive a proxy to account for the "real rate" of physician work varying in geographic areas. The

External Affairs Department 1900 South Avenue, Mailstop: H02-009, La Crosse, WI 54601
Email: ExternalAffairs@gundluth.org Phone: 608-775-1400 Fax: 608-775-6225

ACA created a temporary extension of the PW floor to assist low reimbursed areas in Medicare physician payments, including Gundersen Lutheran and the rest of Wisconsin.

Gundersen Lutheran supports eliminating the adjustment factor for physician work, as the input of work is the same across the Medicare payment localities. Physicians put in the same time, skill, and intensity in patient visits as any other across the country. However, the outcomes, i.e. the work product, is different. **Specifically, we support implementing a standard PW index of 1.0 across all payment localities, which is revenue neutral; or continuing the PW floor of 1.0 until the new payment formulas.** This policy decision by Congress helps to ensure lower Medicare cost regions are not further penalized utilizing the current formula while the non-partisan IOM continues their crucial studies to implement value.

Physician Practice Expense

Since the GPCI's were implemented in 1992, the physician practice expense (PE) accounts for varying input costs associated with non-physician wages, office rent, and equipment, supplies and other miscellaneous expenses.

As part of the ACA, the PE GPCI was re-calculated to assist under reimbursed regions. Coined the Grassley Amendment as sponsored by Senator Chuck Grassley, these modifications were enacted in Sections 3102 and 1008 of the Affordable Care Act (ACA). Specifically, the provisions adjust the Practice Expense (PE) to reflect ½ the difference between the national average and those areas below the national baseline. Set to expire, it is difficult for providers in low reimbursed areas of the country to continue experiencing downward pressure in physician reimbursement. **Therefore, we recommend Congress continue the PE policy in the GPCI payment formula to ensure rural areas are accounted for in terms of their ability to recruit and hire high quality medical providers.** Under a payment formula which results in lower payments in rural areas, particularly in the upper Midwest, it is important some level of relief is provided to the lowest reimbursed areas in the Medicare program.

Rural Ambulance Services

Ensuring patients have access to trauma emergency services is critical to increased survival rates. The notion of strained access is exacerbated in rural areas where Gundersen Lutheran primarily serves both as a provider and through the affiliate Tri-State Ambulance emergency transportation services. Serving both metro and rural areas, Tri-Ambulance serves patients in western Wisconsin, southeastern Minnesota and the corner of northeast Iowa.

As a non-profit healthcare organization, Tri-State Ambulance provides paramedic, advanced life support service with no taxpayer subsidies. This is impressive considering that across America the majority of 911 ambulance providers receive an operational tax-funded subsidy, often as much as 75 percent. The past few years have been financially challenging to the ambulance industry and healthcare in general. Lower insurance reimbursement and higher numbers of uninsured have left countless ambulance providers asking for increased subsidies from their towns or counties. Due to Tri-State's decreased revenue and lower reimbursement, numerous adjustments to its operations have been made without reducing service. However, in order to continue providing high quality service to all of our patients in the region, the payment bonuses for rural areas are key policies and we support their extension.

External Affairs Department 1900 South Avenue, Mailstop: H02-009, La Crosse, WI 54601
Email: ExternalAffairs@gundluth.org Phone: 608-775-1400 Fax: 608-775-6225

Conclusion

Medicare payment policies aimed at targeted areas are key to ensuring healthcare is accessible to all, especially in rural areas where costs of providing services are higher, and revenues are lower due to the fee-for-service reimbursement environment. As the nation transitions to utilizing different models of payment for healthcare services, these important reimbursement policies help specific areas of the country, including Gundersen Lutheran that are low cost Medicare providers. In sum, we support continuing these payment policies in Medicare while we continue to work together on implementing value based reimbursement in healthcare.

Please feel free to contact me with any questions.

Sincerely,

Michael Richards
Executive Director
Government Relations & External Affairs

External Affairs Department 1900 South Avenue, Mailstop: H02-009, La Crosse, WI 54601
Email: ExternalAffairs@gundluth.org Phone: 608-775-1400 Fax: 608-775-6225

Medicare Modernization Act, MMA, Statement

SECTION 508 HOSPITAL COALITION

Statement Submitted to the
U.S. House of Representatives
Ways & Means Subcommittee on Health

by

Section 508 Hospital Coalition

Regarding the Hearing on Expiring Medicare Provider Payment Policies
Wednesday, September 21, 2011

The Section 508 Hospital Coalition is pleased to provide this statement regarding expiring Medicare provider payment policies.

Formed in 2004, the Section 508 Hospital Coalition represents those hospitals that qualified for wage index geographic reclassification pursuant to Section 508 of the *Medicare Modernization Act* (MMA).

Under Medicare's Inpatient Prospective Payment System (IPPS), the payment system used to reimburse hospitals for inpatient services furnished to program beneficiaries, payments are adjusted to reflect the cost of labor in the area where the services are furnished. The basic premise underlying this adjustment is that hospital personnel – nurses, technicians, housekeepers, dietary staff, billing clerks, *etc*. – are more expensive to employ in New York City than in rural Iowa, and payments should be adjusted accordingly.

To adjust payments in this manner, the Centers for Medicare and Medicaid Services (CMS) uses a multiplier called the "wage index." The wage index is calculated by collecting average hourly wage data from each hospital across the country, and developing a national average hourly wage. CMS then determines a local average hourly wage. To define local areas, CMS relies on the Metropolitan Statistical Area (MSA) scheme developed and maintained by the U.S. Office of Management and Budget. CMS develops a distinct average hourly wage for each MSA around the country, and one for the rural portion of each state (*i.e.,* areas not within an MSA). The wage index for an MSA or rural area is the quotient of the average hourly wage for that area divided by the national average hourly wage.

Recognizing that MSAs are not always an accurate reflection of labor markets, Congress in 1989 established a process whereby hospitals could reclassify to a nearby MSA, and if they meet certain criteria, receive the higher wage index of that MSA. Of the more than 3,500 hospitals in the United

States (not including Critical Access Hospitals), approximately 650 hospitals (19 percent) are reclassified each year.

Each year, dozens of hospitals complain to CMS and Congress about shortcomings of the current reclassification system. Most of the complaints center around the use of MSAs as proxies for labor markets, and how grouping hospitals into MSAs creates unjustifiable and unfair reimbursement differentials between hospitals that are physically proximate and competing for labor in the same labor market. Hospitals in these situations that cannot qualify for reclassification for one reason or another assert that the reclassification criteria and process are too rigid, and not overcoming the shortcomings of using MSAs as proxies for labor markets, as it was originally intended to do.

Despite this chorus of complaints, CMS rarely updates or improves the reclassification system. Moreover, when CMS does decide to make a change, most often the change makes it more difficult for hospitals to qualify for reclassification, and reduces the number of hospitals qualifying for reclassification.

In 2003, Congress expressed its frustration with CMS's reluctance to modernize the reclassification criteria by directing CMS to establish a process under which hospitals otherwise not eligible for wage index reclassification could apply and qualify for reclassification. Specifically, Section 508 of the *Medicare Modernization Act* directed CMS to establish a one-time appeals process whereby CMS would develop new criteria that would resolve many of the problems with the reclassification criteria historically raised by hospitals. Hospitals qualifying for reclassification under these revised criteria would be reclassified for a three-year period beginning April 1, 2004. Congress provided $900 million for this purpose. The MMA did not specify the criteria to be used – other than to say that a hospital already eligible for reclassification could not qualify – or direct CMS which hospitals to reclassify. The legislation gave CMS complete discretion to devise the criteria that would apply.

In enacting Section 508, Congress demonstrated a determination that some hospitals suffered from inequitable wage index classifications, and needed extraordinary assistance to rectify our various situations. While not expressly stated in the MMA, we believe that Congress limited the duration of the reclassifications for two reasons: (1) to limit the overall cost of the provision; and (2) because Congress hoped CMS would use this opportunity to modernize the reclassification criteria to permanently incorporate the changes made pursuant to Section 508. Regrettably, CMS has not made any change that would enable the majority of these hospitals to reclassify on their own. As such, they continue to need Section 508 reclassification to overcome inherent labor market unfairness and to continue to effectively serve their communities.

Fortunately, Congress has recognized the ongoing need for Section 508, often paired with the Medicare physician payment formula legislation or "doc fix", and has extended the Section 508 reclassifications five times:

- *Tax Relief and Health Care Act of 2006* – Extended through 2007;
- *Medicare, Medicaid, and SCHIP Extension Act of 2007* – Extended through FY 2008;
- *Medicare Improvements for Patients and Providers Act of 2008*– Extended through FY 2009;
- *Patient Protection and Affordable Care Act of 2010*– Extended through FY 2010; and
- *Medicare and Medicaid Extenders Act of 2010*– Extended through FY 2011.

Under the criteria promulgated by CMS, 120 hospitals qualified for reclassification for the initial 3-year period. In FY 2012, only 91 hospitals from the following states continue to need and benefit from Section 508.

Alabama - 1	Iowa - 4	Pennsylvania -13
Alaska -1	Michigan - 30	South Dakota – 1
California - 1	Mississippi - 3	Vermont -1
Colorado -1	New Jersey -7	Virginia -1
Connecticut - 14	New York - 7	Wyoming -1
Illinois - 2	North Carolina -1	
Indiana - 1	Oregon – 1	

Unless Congress acts to again extend this important provision, the hospitals that benefit from Section 508 will lose millions of dollars in Medicare reimbursements that are necessary to maintain their workforce and serve Medicare beneficiaries in their communities.

Extending Section 508 now is more critical than ever. These hospitals are often the economic engines of their communities, and many of the communities they serve are struggling economically. Hospitals benefiting from Section 508 are in some of the country's most economically hard-hit areas, like Detroit and Scranton. If Medicare payments to these hospitals are further reduced, and these hospitals are forced to reduce workforce as a result, their communities could be further set back on the road to economic recovery and job creation.

Moreover, many of these hospitals, like hospitals across the country, are working to implement and absorb the requirements and Medicare payment-related changes resulting from health reform. Some of our hospitals expect Medicare reimbursement reductions as a result of health reform. Further reimbursement reductions at this vulnerable time could be economically crippling to these facilities.

Although most of the various extensions have been for one-year periods, the qualifying hospitals have come to depend on the additional reimbursements. Hospitals have established programs, hired personnel and built infrastructure thanks to this program. Without the assistance Congress has provided over the past eight years, these hospitals will find it more difficult to recruit and retain essential staff, and to care for Medicare beneficiaries and other patients in their communities.

We recognize that the country is facing difficult economic conditions, and that reducing the deficit is imperative. Nonetheless, Congress still must distinguish programs that require ongoing federal support from those that are better positioned to sustain cutbacks. This program is fundamental to the health of Medicare beneficiaries and economic well-being of our communities.

We further recognize that Congress would prefer to find long-term solutions to some of the programs that have been annually extended. We also would prefer a solution that provides hospitals with more predictability and stability. However, to date, a long-term viable solution has been elusive. Congress has asked CMS, the Institute of Medicine and the Medicare Payment Advisory Commission to propose solutions to some of the problems associated with the wage index and reclassifications. In fact, the same provision extending Section 508 reclassifications for FY 2010 in the Affordable Care Act also required CMS to develop an action plan for

improving the wage index. To date, none of these studies have produced politically or financially viable solutions. Until such time as Congress takes action to reform the wage index and obviate the need for reclassifications, it should continue to maintain a level playing field between the hospitals that benefit from reclassification, and those that need Section 508 to reclassify.

We ask for your leadership to help us protect our hospitals and the patients they serve by extending these reclassifications.

National Association for the Support of Long Term Care, NASL, Statement

September 30, 2011

The Honorable Wally Herger, Chairman
The Honorable Pete Stark, Ranking Member
Subcommittee on Health
Committee on Ways and Means
U. S. House of Representatives
Washington, D.C. 20515

Chairman Herger and Ranking Member Stark:

The National Association for the Support of Long Term Care (NASL) is pleased to submit for the record a statement regarding the Health Subcommittee's hearing on September 21, 2011, regarding Expiring Medicare Provider Payment Policies. We commend the subcommittee for addressing these critical issues, and we would like to call particular attention to the need to resolve the long-standing issue of the Medicare therapy cap.

NASL is a trade association representing providers of both ancillary services and products to the long term and post acute care sectors. Our member companies provide speech-language pathology; physical and occupational therapy; portable X-ray/EKG and ultrasound; pharmacy; long term and post acute care (LTCPAC) information technology systems; and other ancillary services. NASL members also provide products such as complex medical equipment; parenteral and enteral supplies, equipment and nutrients; and additional specialized supplies for post-acute care settings nationally.

History of the Therapy Cap

The therapy cap policy was authorized as part of the Balanced Budget Act of 1997, when an annual financial limit of $1,500 on physical therapy and speech-language pathology services, and a separate $1,500 cap on occupational therapy services were established. The therapy cap was intended to be a temporary policy until the Centers for Medicare and Medicaid Services (CMS) could develop an alternative payment methodology for therapy services for congressional consideration.

Congress has acted numerous times to forestall the effect of the therapy cap policy on seniors and people with disabilities under the Medicare program. This was first accomplished through a series of moratoria on the implementation of the cap, and later through a broad-based exceptions process. Congress took these actions because from the very beginning, there was wide recognition that a cap on therapy services was poor public policy.

National Association for the Support of Long Term Care
1321 Duke Street • Suite 304 • Alexandria, Virginia 22314-3563
(703) 549-8500 • FAX (703) 549-8342 • www.nasl.org

Flaws in the therapy cap policy are well chronicled, and they include the following concerns:

- Sets an arbitrary dollar limit on therapy services without regard to patient need
- Not tied to clinical indicators or standards of care for therapy conditions
- Overrides the therapist's clinical decision-making and disrupt plans of care
- Hinders quality outcomes and threatens quality of care for individuals with therapy needs above the cap amount
- Not an effective control on utilization, and does not address all segments of growth in therapy services

Impact of Therapy Cap Policy

In January 2012, the arbitrary Medicare per beneficiary therapy caps will be fully imposed unless Congress acts to extend the current exceptions process. NASL believes that the exceptions process must be extended to avoid unduly affecting those beneficiaries who are most in need.

An arbitrary cap on therapy services without regard to the clinical appropriateness of care discriminates against the most vulnerable of our Medicare beneficiaries. Beneficiaries who experience stroke, neuromuscular diseases, hip fracture, Parkinson's disease, diabetes, arthritis or osteoporosis are most likely to be harmed by this arbitrary limitation on services.

The therapy cap reduces access to rehabilitation services for Medicare beneficiaries by limiting their choice of providers, forcing them to bear 100 percent of the cost of their care once they exceed it, or self-rationing their care to avoid exhausting their benefits. The therapy cap shifts costs, delays care, and reduces an individual's ability to remain independent in their community.

The arbitrary cap also prevents beneficiaries from receiving the rehabilitation care they need in a timely fashion. Beneficiaries who fail to receive the rehabilitation care they need from a physical therapist, occupational therapist, or speech-language pathologist are more likely to require higher-cost interventions to remain functional. The harmful effect of the cap is worsened by coupling physical therapy and speech-language pathology services under a single cap.

In 2006, Congress allowed the therapy caps to go into effect but authorized Medicare to allow exceptions for beneficiaries needing additional rehabilitation services based on diagnosis, clinician evaluation and judgment. Congress has acted a number of times to extend the exceptions process for beneficiaries, but the exception is authorized only through December 31, 2011.

Extend the Therapy Caps Exceptions Process

This is a propitious time for the Subcommittee on Health to review the therapy cap exceptions process. The process has been in place for nearly six years, and the nearly annual specter of arbitrary limits being imposed on the provision of therapy services continues to cause distress for Medicare beneficiaries and their families, as well as being a source of regulatory uncertainty and concern for therapy providers. Congressional efforts to extend the exceptions process have protected beneficiary access to rehabilitation care, but the uncertain nature of the legislative process has led to a number of interruptions in the continuity of care to Medicare patients.

The problem flared again last year when therapy caps were imposed in January and February while Congress debated Medicare legislation. Thousands of Medicare beneficiaries suffered disruption in their treatment programs because they had reached their therapy cap limits. The therapy cap is a particularly harsh policy for nursing home residents. Our members saw many of their patients curtail therapy treatments when they hit the arbitrary caps, and the progress they had achieved in restoring their functional status often was lost. This disruption in the continuity of care added to the cost of future treatments, and it caused anguish for patients that suspended their rehabilitative care.

The near-term policy priority for Congress should be to maintain coverage of medically necessary therapy services for Medicare beneficiaries. We recommend that the therapy cap exceptions process be extended until a new payment system is put into place to ensure that Medicare beneficiaries needing therapy services will receive those services without delay, or unfair financial burden. The exceptions process is a necessary safety net for many Medicare beneficiaries.

Principles for an Alternative Payment System for Therapy Services

NASL members recognize that we need a new payment system for therapy services that better aligns beneficiary needs with the services delivered. We are eager to work with Congress and CMS to develop a condition-based payment system as an alternative to the therapy cap. NASL members have been active participants in two recent CMS sponsored projects – the Short Term Alternatives for Therapy Services (STATS) project, and the Development of Outpatient Therapy Alternatives (DOTPA) project

NASL also sponsored a research project in 2008 that was conducted by The Moran Company to develop a proposal for an alternative therapy payment system. The project used 2004-2006 billing data for more than 200,000 patients receiving Part B therapy services in SNF settings. NASL has briefed CMS on the study and provided the agency with copies of the study. Key features of the NASL's proposed payment system would include the following items:

- **Providers would be paid based on an "episode of care" (EOC)** which is defined as all care provided by therapy disciplines in one site of care without a break of 60 days or more (no therapy services billed during that time) and without a discharge from and readmission to a SNF.

- **The EOC would be mapped to relevant clinical characteristics that influence the cost of therapy** using a combination of ICD-9 diagnosis codes and condition codes that CMS may develop to include in the claims.

- **Providers would be paid for short-term outlier cases.** We found that patients were seen by one or more therapy disciplines over a day or two with no further treatment. These appear to be cases in which patients were being evaluated or where therapy was started and immediately discontinued for various reasons. These cases have consistent cost profiles that support a flat outlier payment. This payment could be set either per therapy discipline, or by bundling disciplines in the SNF setting and provide an outlier payment for one, two, or three disciplines or for each combination.

- **Providers could request exceptions for unusually high cost, complex cases.** For a small number of complex cases, the provider should be able to request an exception based on medical necessity. The payment would be triggered by a defined point beyond the average length of episode of care (e.g., two standard deviations), at which time payment would be based on a weekly rate based on the mean cost per week that decreases each week by a fixed percent for some limited number of weeks. The mean cost per week may be set in the SNF based on one, two, or three treating disciplines, or by specific combination of disciplines, and may be set by specific discipline separately in outpatient settings.

- **Weights could be set for the EOCs based on mean costs.** The mean costs for EOCs that map to different condition groupings can be determined with or without comorbidities and other payment adjustor variables. We would include short-term outlier EOCs in the weight setting, as they appear to have a relatively predictable volume and cost. Comorbidities and other payment adjustment variables can be either incorporated into weights directly or assigned a separate percentage of the budget to be allocated as add-on payments. The weights are multiplied by a conversion factor set by CMS to allow for budget neutrality.

- **When care is interrupted by a change in health condition or other circumstance outside the provider's control, a partial payment adjustment mechanism would be provided.** For example, payment is pro-rated based on the mean length of episode for the applicable EOC.

- **Payments would be geographically adjusted using an appropriate wage index.**
- **Provision would be made for annual updates based upon selected economic indicators.**

Identification of these principles is an important step toward developing a new payment system that would ensure that beneficiaries receive the high quality, comprehensive therapy services they deserve, and that Medicare pays for value-driven services. We look forward to continuing this dialogue with you to ensure that Medicare patients continue to receive medically necessary therapy services without delay, or undue financial burden. We applaud your leadership on this issue, and NASL would be pleased to work with you to develop an alternative payment system.

Thank you for the opportunity to offer these comments on behalf of millions of frail, elderly, and disabled Americans we provide services to each day.

Please feel free to contact me by telephone at (703) 549-8500, or by e-mail at cynthia@nasl.org with any questions that you may have regarding these comments.

Sincerely,

Cynthia K. Morton
Executive Vice President

National Rural Health Association, NRHA, Statement

Erin Mahn
National Rural Health Association
1108 K Street NW, 2nd Floor, Washington, DC 20005
202-639-0550 (Phone)
emahn@NRHArural.org
Hearing on Expiring Medicare Provider Payment Policies, September 21, 2011

Thank you for your consideration of the following comments. If you would like additional information, please contact Maggie Elehwany, Vice President of Government Affairs at melehwany@NRHArural.org or 202-639-0550.

Testimony of National Rural Health Association
House Ways and Means Subcommittee on Health
Hearing on Expiring Medicare Provider Payment Policies
September 21, 2011

The National Rural Health Association (NRHA) thanks the House Ways and Means Subcommittee on Health for the opportunity to submit testimony. NRHA is pleased to detail to the committee the importance of several of the expiring Medicare payment policies to rural patients and providers.

NRHA is a nonprofit membership organization with more than 22,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care infrastructure, including rural community hospitals, critical access hospitals, doctors, nurses and individuals. We work to improve rural America's health needs through government advocacy, communications, education and research.

Several of these payment provisions were created by Congress to improve access to care in rural America, and have been successful in meeting that goal. Continuation of these payment provisions is crucial, and NRHA has long sought legislation to make the payments permanent. However, NRHA certainly recognizes the importance of examining these Medicare provider payment policies, many of which expire on or before December 31, 2011. We agree with Chairman Herger that it is important to reexamine the impact of Medicare payment policies to ensure that they continue to improve access to care, especially for rural patients.

Rural Americans, on average, are older, sicker and poorer than their urban counterparts. Rural America needs the extension of these programs to retain physicians and promote rural physician recruitment. Without the extension of these programs, the negative impact on the rural health infrastructure and local economies would be devastating. Medicare beneficiaries should not lose access to local services and care.

This testimony focuses on NRHA's concerns for rural beneficiaries and the need to provide security to the fragile rural health care safety net. Our primary concern is payment equity and access to care in the Medicare system, where rural beneficiaries are most likely to enroll.

The importance of some of the expiring provisions the Subcommittee will be examining include:

Physician Work GPCI

Medicare and Medicaid – major components of rural health care – pay rural providers less than their urban counterparts. Rural health care providers operate on a very thin margin and many rural communities have severe medical workforce shortages. Only 10 percent of physicians practice in rural America even though a quarter of the population lives in these areas. Although rural physicians put as much time, skill and intensity into their work as physicians in urban areas, rural physicians are reimbursed at lower rates. In recognition of the challenges rural facilities face in recruiting physicians, the Geographic Practice Cost Index's work geographic index floor was set at 1.0. To recruit and retain physicians, this GPCI payment must be continued. GCPIs adjust payments for geographic differences in the cost of providing services,

including for physician work (or cost-of-living adjustments), practice expenses and medical liability insurances. With rising practice costs, extension of GPCI payments makes rural practice financially viable and allows communities to retain their providers. They also provide incentive for those interested in entering rural medical practice. It is vital that these payments are continued and improved.

Direct Billing for Technical Component of Pathology Services

Since the creation of the Medicare program, independent laboratories have been allowed to bill Medicare directly for certain clinical laboratory services. These independent laboratories allow small and rural hospitals to access high quality services when they do not have the volume or financial resources to support their own state-of-the-art laboratory. Independent laboratories provide pathology services to multiple hospitals, receiving the volume necessary to purchase the most up-to-date equipment and employ skilled laboratory staff. A hospital can utilize any independent laboratory for these services, creating competition among laboratories for delivery services and allowing hospitals to choose the laboratory that best meets their needs. Without this extension, hospitals would have to absorb new costs without a payment increase. This could result in limited access to surgical services for Medicare beneficiaries near their residence. This could result in beneficiaries delaying treatment leading to poorer outcomes and increased costs when complications arise. Congress has recognized the importance of this hospital and independent lab arrangement throughout the years by "grandfathering" independent labs into this program. Under certain circumstances these "grandfathered" facilities are allowed to continue billing Medicare directly for services. An extension would allow independent laboratories to bill Medicare directly for certain clinical laboratory services.

Extension of Improved Payments for Low-volume Hospitals

Federal regulations have established various payment formulations within Medicare to help Sole Community Hospitals (SCHs), Medicare Dependent Hospitals (MDHs) and low-volume hospitals remain viable. These hospitals, located in rural areas, are more vulnerable to the limitations of the Inpatient Prospective Payment System. The current inpatient payment rates do not account for the fact that most rural facilities do not or cannot operate on the same economies of scale as a large, urban hospital. This important provision helps low-volume rural hospitals that cannot make ends meet under the PPS system, but do not want to convert to or do not qualify for Critical Access Hospital status.

Mental Health Add-On Payment

Workforce shortages also create inaccessibility for mental health care in rural areas. A vast majority of rural areas are designated as mental health professional shortage areas and most rural counties do not have a psychiatrist or psychologist. Marriage and family therapists or licensed professional counselors are often the only mental health professionals in remote rural and frontier areas. The expiration of the mental health provider reimbursement will cause an even larger shortage in mental health services. These payments are crucial for ensuring access to mental health services.

Ambulance Add-ons

Distance and geographic barriers play a major role in access to health care in rural America. For many rural areas, emergency medical services are often the front-line providers, required to respond to both emergency and non-emergency events. Often composed of volunteer

providers, rural ambulance services have found it difficult to keep their doors open due to inadequate Medicare payments and inappropriate payment denials by Medicare claims processors. To help alleviate this burden and ensure ambulance services in rural America, the bonus payment for ground and air ambulance trips was created to build a stronger, more financially viable rural emergency network. Without the extension of this program, rural Americans will not have their needs of rural emergency medical services met. Expiration will jeopardize the level of care that ambulance services can deliver and increase the time it takes to respond to patients.

Outpatient hold harmless provision

Small rural hospitals (100 beds or fewer) receive Medicare payments so that they are held harmless from the effects of the outpatient prospective payment system. Eligible hospitals will receive a partial and declining hold harmless payment until the end of CY2009. In CY 2006, hospitals received 95 percent of any difference between their PPS payment and payments under the previous system, 90 percent in CY 2007, and 85 percent in CY 2008 and CY 2009. Since 2009, this provision has been extended on multiple occasions. We urge the committee to do so again.

Conclusion

These programs protect the rural health care safety net and provide critical access to health care for rural Americans. Rural physicians and hospitals generate billions of dollars for the local economy. Studies at the National Center for Rural Health Works at Oklahoma State University have found that one fulltime rural primary care physician generates about $1.5 million in revenue, and creates or helps create 23 jobs. Rural health care systems make huge economic contributions to their communities. Reducing rates for rural providers will force many facilities to offer reduced services or even close their doors, further reducing access to care for rural Americans. Rural hospital closures also devastate local economies. In the past, a closed hospital has meant as much as a 20 percent loss of revenue in the local rural economy, 4 percent per capita drop in income, and a 2 percent increase in the local unemployment rate.

Medicare Provider Payment Policies are critical to the ability of our rural health care safety net and the ability for our health care providers to continue to provide quality care to rural Americans. The development of permanent policies that address these issues is vital to the ongoing success and viability of the rural health care safety net. In the past, members of Congress have looked to the bi-partisan Rural Hospital and Provider Equity Act (R-HoPE) to address these issues in the long-term and provide rural providers with the certainty they need. We encourage the committee to look to that legislation (S. 1157, 111th Congress) as a guide for addressing all these issues in the long-term.

NRHA looks forward to continuing working with members of the Subcommittee and Congress. We thank Chairman Herger and the Subcommittee for the opportunity to provide testimony.

PTPN, Statement

WITH NETWORKS IN:
Arizona • California • Colorado • Florida • Louisiana • Maine
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September 19, 2011

The Honorable Wally Herger
The Honorable Pete Stark
Subcommittee on Health
House Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Herger and Ranking Member Stark:

As the nation's first and largest specialty network of rehabilitation therapists in independent practice, PTPN and its members who function as small businesses are pleased to offer this statement to the Health Subcommittee of the House Committee on Ways and Means with respect to the September 20 hearing that will focus on expiring provisions of the Medicare payment system. PTPN has led the rehabilitation industry in national contracting, quality assurance and provider credentialing since 1985, elevating the standard of therapy practice. PTPN continued its role as a rehab pioneer by becoming the first organization of its kind to launch a mandatory third-party outcomes measurement program in 2006. The network has more than 1,000 provider offices (including 3,500 physical therapists, occupational therapists and speech/language pathologists) in 23 states. PTPN contracts with most of the major managed care organizations in the nation, including insurers, workers' compensation companies, PPOs, HMOs, medical groups and IPAs. All members of PTPN must be independent practitioners who own their own practices.

As you proceed with your efforts to reform and ensure stability of the Medicare program -- particularly the Physician Fee Schedule -- we would urge you to be continuously mindful of the independent rehabilitation therapy providers and suppliers who function as small businesses and who are an important, integral element of our delivery system. PTPN members provide a valuable service to communities across the nation and they do so in a convenient, cost-effective manner. But as is typical for small businesses, narrow margins are jeopardized when a significant sector of its market cuts reimbursement without regard to the value of the service provided. Moreover, when such an action is unpredictable and is taken by an influential payer such as Medicare, the effect is to negatively influence the business environment and create an untenable situation for the providers. This is especially true because private healthcare payers base their payments on Medicare's fee schedules and policies as well. Most importantly, the Medicare beneficiaries are left in a vulnerable position, unable to depend on the access to convenient, cost-effective, high-quality care to which they have become accustomed.

www.ptpn.com
26635 West Agoura Road, Suite 250 • Calabasas, California 91302 • (818) 883-PTPN

PTPN comments on issues of relevance to the hearing and other pertinent Medicare issues address the following topical areas:

- Medicare per Beneficiary Therapy Caps
- Sustainable Growth Rate
- Curbing Overutilization of Therapy
- Electronic Health Records

Therapy Caps
In January 2012 the arbitrary Medicare per beneficiary therapy caps will be fully imposed unless Congress acts to extend the current exceptions process or repeal the caps permanently. While the latter is our overwhelming preference and, in our view, the most sensible Medicare policy, at minimum the exceptions process must be extended to avoid unduly affecting those beneficiaries who are most in need.

Unless Congress acts, the therapy caps will once again arbitrarily end Medicare's coverage of outpatient physical therapy, occupational therapy, and speech-language pathology services once a beneficiary has received an artificial dollar amount of services ($1,870) of services in an entire calendar year. This set amount is without respect to a patient's condition or the need for services or the use of services at other times during a calendar year for either the same or a different condition.

It applies to Medicare beneficiaries in all outpatient health care settings with the exception of outpatient hospital departments. Beneficiaries who receive Part B rehabilitation services within a skilled nursing facility, a therapist's or physician's office, a home health agency, or a rehabilitation agency are subject to the arbitrary cap.

Some 14.5 percent[1] or 640,000 Medicare beneficiaries who receive outpatient rehabilitation services per year are estimated to exceed the existing statutory therapy cap if Congress does not extend the exceptions process. Once the limit has been reached, beneficiaries who require additional services are responsible for the total cost. Seniors and individuals with disabilities with the most significant rehabilitation needs will have to decide between foregoing necessary care, changing providers of care to the more costly hospital setting which Medicare will pay for, or paying 100% of the cost out-of-pocket. Beneficiaries who experience stroke, hip fracture, Parkinson's disease, diabetes, arthritis or osteoporosis are most likely to be negatively affected by the therapy caps. Thus, beneficiaries with impairments and disabilities are adversely and unfairly impacted by this arbitrary payment policy.

Ciolek, DE, Wenke H. *Utilization Analysis: Characteristics of High Expenditure Users of Outpatient Therapy Services CY 2002.* Final Report to the Centers for Medicare and Medicaid Services. November 22, 2004

PTPN urges Congress to extend the exceptions process for 2-3 years and direct the Centers for Medicare and Medicaid Services (CMS) to prepare "an alternative payment method" which was envisioned by the Balanced Budget Act of 1997. Specifically, Congress should direct CMS to utilize the exceptions process to incentivize the collection and submission of quality information (e.g., **functional outcomes data**) which could be used to describe the type and amount of care that is needed by specified patients or groups of patients. Legislative language that would effect this policy is appended to the end of this letter.

Sustainable Growth Rate (SGR)
At the end of this year, a congressionally passed waiver of the statutory sustainable growth rate (SGR) formula, will expire. As a result, due to this flawed formula, CMS has announced in the proposed rule that the physician fee schedule update for CY 2012 will be negative 29.4%. Moreover, because of the cumulative nature of the formula, updates for the foreseeable future will be negative as well. Not only is the SGR an example of a government policy (legislation) that does not work, but it also illustrates that efforts of Congress to undo this mistake – in the absence of complete repeal – are only making a bad situation worse.

For years, providers and beneficiaries have been told by both political parties that they are committed to a permanent fix for this flawed formula. Yet, because of the cost of undoing the unintended budgetary consequences of legislation enacted by Congress, the Medicare program and the beneficiaries it serves are placed in jeopardy.

The Congressional Budget Office estimates that replacing the SGR with a payment based on the Medicare Economic Index carries a ten-year score upward of $300 billion. The same solution could have been implemented seven years ago for about one-tenth of that cost. But more frightening is the finding that, if left unaddressed, repealing and placing SGR five years from now will carry the staggering score of $600 billion.

It is time for Congress to "bite the bullet" and address this dysfunctional law with a permanent replacement. Therapists and physicians operate as small businesses and cannot – and should not -- be expected to participate in a program that provides no stability or predictability in terms of payment for services. Further, if Medicare reimbursement is reduced by 30%, thousands of private managed care contracts based on Medicare rates will also be cut, millions of all types of healthcare providers nationally, and certainly driving many out of business.

Obviously, the best approach is to have this accumulated debt addressed by the Joint Select Committee on Deficit Reduction. However, this appears more logical than likely. In the absence of such action, the responsibility will fall to the committees of jurisdiction – including Ways and Means -- to remedy this problem. It is important to keep in mind that **even if the Select Committee does address it, the effects of those actions are targeted for 2013-2021; meaning that the aforementioned 2012 drastic negative update (29.4%) will be implemented. Therefore, your committee must assume leadership** and address this profound policy problem either alone or in conjunction with the Select Committee.

If the Committee (and Congress) chooses the "kick the can down the sidewalk" approach, a 3-5 year period of stability and predictability is strongly encouraged during which alternative reimbursement methods currently being tested can be evaluated for implementation as acceptable replacements for the SGR.

Curbing Overutilization of Therapy

Currently under Medicare Part B there are various ways to bill for services. One policy in particular -- the Stark II in-office ancillary services exception to the self-referral law -- carries a proven propensity for overutilization. PTPN believes, and evidence shows, that elimination of this exception could provide potential cost-savings and improve the integrity of the services delivered and paid for by the Medicare program. The Office of the Inspector General of the United States Department of Health and Human Services has continued to identify a high rate (78 to 91%) of inappropriate billing of physical therapy services billed incident to a physician's professional services. Elimination of these practices must be addressed in an effort to provide a sustainable payment system for providers that serve the Medicare Part B program and ensure we are paying for only services delivered appropriately by qualified professionals of that discipline.

Electronic Health Records

PTPN urges Congress to extend to non-physician providers the same incentives for providers to establish electronic health records. Non-physician providers such as independent physical therapists were not included in the federal programs that encourage and reward the adoption of health information technology. Yet, our network members provide an important and valuable service that should be coordinated and communicated electronically. What sense does it make to encourage an information superhighway, but only allowing a certain select type of car to drive on it? The sooner Congress and the administration can set the standards for an interoperable electronic health records the sooner waste and redundancy can be wrung out of the system.

Conclusion
In summary, the above-discussed issues have beneficial effects on the therapy providers, the patient, and the Medicare system in the following ways: Repealing the SGR has major impacts on the provider but secondary benefits for the patient; the therapy cap repeal (extending the exceptions process) is primarily a Medicare beneficiary issue; assisting non-physician providers in accessing health information technology is beneficial to both PTs and their patients, and to the degree to which it creates efficiencies, the Medicare program; the benefits of curbing overutilization inure specifically to the Medicare program.

On behalf of PTPN, thank you for your continued efforts to create a more stable, predictable and effective Medicare payment system. Our organization is eager to continue to work with the Committee, Congress and CMS to help preserve and strengthen the Medicare program.

Sincerely,

Michael Weinper

Michael Weinper, MPH, PT, DPT
President/CEO

See attached ADDENDUM below:

Proposed Therapy Cap Alternative

Exceptions Process Based on Submission of Quality and Outcomes Data

ADDENDUM

Proposed Therapy Cap Alternative

Exceptions Process Based on Submission of Quality and Outcomes Data

"The DCS Exception"

(a) BENEFICIARY CONDITION AND OUTCOMES DATA

1. **In General.** – No later than January 1, 2012, the Secretary of Health and Human Services ("Secretary") shall in collaboration with national professional associations representing each therapy discipline (including physical therapy, speech-language pathology, and occupational therapy) and those associations that represent providers or suppliers who offer services to beneficiaries in need of such services implement an initiative to:
   - (a) identify general and discipline-specific data elements regarding patient condition, including severity of condition,
   - (b) develop general and discipline-specific patient assessment processes to collect such data,
   - (c) identify and measure appropriate indicators, such as age, illness, severity and settings, that may be used in assessing appropriate payment for services, and
   - (d) implement a data collection system ("DCS") using the above-referenced discipline-specific assessment tools that measure the quality and efficiency of therapy treatment.

2. **Sites. --**The Secretary shall ensure that the initiative includes a variety of geographic sites and practice settings including nursing facilities in which the therapy disciplines furnish services under Medicare Part B.

(b) SERVICES NOT SUBJECT TO PER BENEFICIARY CAP

1. In General. -- Any provider or supplier that furnishes outpatient therapy services to fee-for-service Medicare beneficiaries or outpatient rehabilitation services provided in a SNF under consolidated billing provision and submits claims to the Medicare program for such services, may voluntarily agree to participate in the DCS by submitting data on quality measures or patient outcomes to the Secretary.

2. Beneficiaries receiving treatment from a person or entity participating in the data collection initiative described in this paragraph shall not be subject to financial limitations under section 1833(g)(2) of the Social Security Act (42 U.S.C.1385l(g)(2)).

(c) REPORTS. -- The Secretary shall report to the Congress on (a) the adequacy of the assessment processes in reflecting the quality and efficiency of therapy treatment, (b) identify or recommend alternative data elements and assessment processes that would reflect the quality and efficiency of therapy treatment, and (c) payment methods based on beneficiary need and effectiveness of rehabilitation as alternatives to the beneficiary therapy caps. The Secretary shall submit an interim report to the appropriate committees of the Congress no later than October 1, 2012, and a final report to such committees no later than April 1, 2013.

Rural Hospital Coalition, Statement

Statement of the Rural Hospital Coalition

House Committee on Ways and Means
Subcommittee on Health

Hearing on Expiring Medicare Provider Payment Policies

September 21, 2011

Submitted by Nancy Taylor
On Behalf of the Rural Hospital Coalition
202.331.3133

Statement of the Rural Hospital Coalition

House Committee on Ways and Means
Subcommittee on Health

Hearing on Expiring Medicare Provider Payment Policies

September 21, 2011

The Rural Hospital Coalition would like to thank Chairman Wally Herger (R-CA), Ranking Member Pete Stark (D-CA), and other Members of the Health Subcommittee for holding a hearing on the expiring Medicare provider payment policies and for the opportunity to submit testimony on this important topic. The impact of Medicare provider payment policies on rural beneficiaries, health care and communities cannot be understated.

The Rural Hospital Coalition represents nearly 20% of rural hospitals, with almost 200 facilities located across thirty-one states. Our hospitals are major drivers of many rural communities, providing jobs, revenue and the health care needed to keep rural Americans thriving. In many rural communities, rural hospitals serve as one of, if not *the*, largest employers. Rural hospitals can account for a full 20% of the revenue a rural community sees in a year. In addition, the existence of a high-quality hospital in a rural community is key to the economic development of that local community. A rural hospital is often a vital element in attracting investment and new employers to a rural community. Furthermore, a single hospital often serves as the sole provider of care for a community. Finally, rural Americans already earn significantly less than their urban counterparts, are more likely to live at or below the federal poverty level, and are more likely to experience worse health overall[1]. Rural hospitals are therefore vital to the communities they serve.

However, rural hospitals consistently struggle financially, a situation exacerbated by historically inequitable Medicare reimbursement rates. Because rural hospitals serve residents who are less likely to have employer-provided health insurance, prescription drug coverage, and less likely to be covered by Medicaid, these hospitals provide higher rates of uncompensated care than metropolitan facilities[2]. And while Medicare payments to rural hospitals are less than those paid to urban hospitals, the payment policies under consideration today help offset these and other factors faced by rural hospitals[3]. Allowing the current rural Medicare payment policies to expire could not only threaten to deprive rural Americans of their only point of access to local health care, it would also likely weaken the economic backbone of these and surrounding communities.

We certainly appreciate that, in light of the current necessity to focus on deficit reduction, it is important to ensure that these payment policies are serving their underlying purposes and that extending these policies is truly necessary. Of the Medicare payment policies expiring before December 31, 2012, the policies that are of greatest importance to rural hospitals and their

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[1] National Rural Health Association, What's Different about Rural Health Care?, http://www.ruralhealthweb.org/go/left/about-rural-health/what-s-different-about-rural-health-care, Accessed September 18, 2011
[2] Id.
[3] Id.

communities were last estimated by the Congressional Budget Office ("CBO") to cost a total of $2.3 billion over ten years (see enclosed for the full list of Medicare extenders vital to rural hospitals). This estimate amounts to less than one tenth of the total cost of extending all expiring payment policies under consideration today and it amounts to roughly 0.2% of the projected total Medicare spending over the next decade. Furthermore, while these provisions have a small impact on overall Medicare expenditures, they provide a much-needed lifeline to rural communities, the beneficiaries who live there, and to hospitals and communities across the country.

Section 508 - Area Wage Index Reclassification
The area wage index is used to adjust payment rates to account for estimated regional differences in the cost of paying hospitals and their employees. Hospitals in areas with a higher wage index receive higher Medicare payments for the same services than those hospitals in areas with a lower wage index. Section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") allowed hospitals meeting certain criteria to be reclassified into a higher wage-index area. This reclassification ensures that hospitals in so-called low wage index areas can afford to provide these same services to their patients, which do not necessarily cost less in low wage index areas. The reclassification also ensures that rural hospitals remain active employers and job creators, allowing them to offer competitive salaries to nurses, technicians and other employees who would otherwise travel to nearby higher wage index areas, diminishing the ability of these hospitals to offer the highest quality care to rural patients.

Outpatient Hold Harmless
The outpatient hold harmless provision was enacted by Congress to partially protect hospitals from substantial reductions in payments that occurred when the Centers for Medicare & Medicaid Services ("CMS") terminated cost-based reimbursement for outpatient services and began using the Outpatient Prospective Payment System ("OPPS"). The Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") extended this provision and allowed Sole Community Hospitals ("SCHs") with more than 100 beds to be eligible for this adjustment. As noted above, rural hospitals continue to struggle financially, and are not capable of absorbing the additional losses associated with removing the hold harmless provision. The CBO estimate for extending this provision for one year in 2010 was approximately $200 million, a minor cost compared to the $19 billion in total Medicare spending on outpatient services in 2007 alone.

Technical Component for Certain Pathology Services
The technical component for certain pathology services provision allows independent laboratories to bill Medicare directly for certain clinical laboratory services they provide for hospitals. Allowing this payment policy to expire would shift the costs of clinical laboratory services onto hospitals. This would significantly burden rural hospitals, which often rely heavily on independent laboratories for surgical pathology services.

In addition to the payment policies expiring on or before December 31, 2011, there are at least five additional payment policies that will expire on September 30, 2012 □ a mere nine months after the policies that today's hearing is focused on (see enclosed for a complete list of Medicare payment policies that affect rural hospitals). Of the policies expiring in 2012, the two discussed below are most critical to rural hospitals.

Improved Payment for Low-Volume Hospitals
The improved payment for low-volume hospitals applies a percentage add-on for each Medicare discharge from a hospital that is located 15 road miles or more from another hospital[4], and has less than 1,600 discharges during a fiscal year. This provision affords qualifying hospitals an enhanced payment to account for the higher incremental costs associated with a low volume of discharges, as compared to the lower costs incurred per patient at higher volume hospitals. The enhanced payment is not provided after a one-time qualification, but requires that a hospital provide sufficient evidence to demonstrate that it continually meets the discharges and distance requirements, ensuring that hospitals which do not consistently qualify for the payment are not unjustly enriched by a one-time qualifying discharge rate or distance measurement.

Medicare Dependent Hospital Program
The Medicare Dependent Hospital ("MDH") program dates back to 1987, and was "intended to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges."[5] Congress applied this designation to rural hospitals with fewer than 100 beds, not classified as an SCH, and having at least 60% of inpatient days or discharges covered by Medicare. As noted by the Medicare Payment Advisory Commission ("MedPAC"), a greater dependence on Medicare makes such hospitals more financially vulnerable to the prospective payment system ("PPS"). The MDH designation mitigates this financial risk, providing an enhanced payment to account for reduced payments under PPS. Additionally, the MDH designation provides small rural hospitals assurance that if its caseload falls by more than 5 percent due to circumstances beyond its control, the MDH will receive such payments as necessary to cover fixed operating costs. This designation allows many rural hospitals to keep their doors open. This provision was extended under the Patient Protection and Affordable Care Act, and was then scored by CBO as a 0.

We hope that this testimony provides insight into the impact that these Medicare payment policies have on sustaining health care delivery in rural America. Thank you, and we look forward to working with all Members on these important issues.

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[4] This applies only to "subsection (d) hospitals" Not including psychiatric hospitals, rehabilitation hospitals, children's hospitals, hospitals with average inpatient lengths of stay greater than 25 days, or cancer centers.
[5] MedPAC, *Summary of Medicare's special payment provisions for rural providers and criteria for qualification*, June 2001, at 142.

Medicare Extenders

Fall 2011

As providers of health care in America's rural communities, we have a special understanding of the adverse impact failure to pass these extenders would have on beneficiaries and the providers on which they depend. Below is a list of provisions that that have been addressed by Congress in the past. We request your attention and action to pass legislation that, at a minimum, will extend these policies beyond their current expiration.

- **Hospital wage index improvement** Extended reclassifications under section 508 of the Medicare Modernization Act (P.L 108-173). The estimated cost is approximately $300 million over ten years.
  - *Medicare and Medicaid Extenders Act § 102 extends the reclassifications through FY 2011.*

- **Extension of improved payments for low-volume hospitals** Applied a percentage add-on for each Medicare discharge from a hospital 15 road miles from another hospital[6] that has less than 1,600 discharges during the fiscal year. The estimated cost is approximately $200 million over ten years.
  - *Patient Protection and Affordable Care Act § 3125 made this policy effective through fiscal years 2011 and 2012.*

- **Extension of outpatient hold harmless provision** Extended outpatient hold harmless provision and allows Sole Community Hospitals with more than 100 beds to also be eligible for this adjustment. The estimated cost is approximately $200 million over ten years.
  - *Medicare and Medicaid Extenders Act § 108 extends the outpatient hold harmless provision through December 31, 2011.*

- **Extension of exceptions process for Medicare therapy caps** Extended the process allowing exceptions to limitations on medically necessary therapy. The estimated cost is approximately $900 million over ten years.
  - *Medicare and Medicaid Extenders Act § 104 extends the therapy caps exception process through December 31, 2011.*

- **Extension of payment for the technical component of certain physician pathology services --** Extended provision that allows independent laboratories to bill Medicare directly for certain clinical laboratory services. The estimated cost is approximately $100 million over ten years.
  - *Medicare and Medicaid Extenders Act § 105 extends the ability of independent laboratories to receive direct payments for the technical component of certain pathology services through December 31, 2011.*

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[6] This applies only to "subsection (d) hospitals" Not including psychiatric hospitals, rehabilitation hospitals, children's hospitals, hospitals with average inpatient lengths of stay greater than 25 days, or cancer centers.

- **Extension of the work geographic index floor under the Medicare physician fee schedule** Extended a floor on geographic adjustments to the work portion of the fee schedule, with the effect of increasing practitioner fees in rural areas. The estimated cost is approximately $600 million over ten years.
  - *Medicare and Medicaid Extenders Act § 103 extends the existing 1.0 floor on the "physician work" index through December 31, 2011.*

- **Extension of ambulance add-ons** Extended bonus payments made by Medicare for ground and air ambulance services in rural and other areas. The estimated cost is approximately $100 million over ten years.
  - *Medicare and Medicaid Extenders Act § 106 extended the increased Medicare rates for ambulance services, including in super rural areas, through December 31, 2011.*

- **Extension of certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities** Extended Sections 114(c) and (d) of the Medicare, Medicaid and SCHIP Extension Act of 2007. The estimated cost is approximately $200 million over ten years.
  - *Patient Protection and Affordable Care Act § 3106 extended the payment rules to July 1, 2012.*

- **Extension of physician fee schedule mental health add-on** Increased payment rate for psychiatric services delivered by physicians, clinical psychologists and clinical social workers by 5 percent. The estimated cost is approximately $100 million over ten years.
  - *Medicare and Medicaid Extenders Act § 107 extended the five percent increase in payments for certain Medicare mental health services through December 31, 2011.*

- **Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas** Reinstated the policy included in the Medicare Modernization Act of 2003 (P.L. 108-173) that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals. This provision in the Medicare and Medicaid Extenders Act was scored by CBO as a 0.
  - *Medicare and Medicaid Extenders Act § 109 extended this policy through July 1, 2012.*

- **Extension of Medicare Dependent Hospital Program** Extended the designation to rural hospitals with fewer than 100 beds, not classified as an SCH and having at least 60% of inpatient days or discharges covered by Medicare. This provision in the Patient Protection and Affordable Care Act was scored by CBO as a 0.
  - *Patient Protection and Affordable Care Act § 3124 extended this policy through September 30, 2012.*

- **Extension of Community Health Integration Models** PPACA § 3126 removed the cap on the number of eligible counties in a State. This provision in the Patient Protection and Affordable Care Act was scored by CBO as a 0.
  - *Expires September 30, 2012.*

West Michigan Medicare Equity Coalition, WMMEC, Statement

West Michigan Medicare Equity Coalition

Testimony for the Record
House Committee on Ways &Means
Hearing on Expiring Medicare Provider Payment Policies

September 22, 2011

Section 508 Area Wage Index (AWI) protection has corrected a flaw to the Medicare payment methodology that, if unaddressed, would have cost West Michigan hospitals hundreds of millions of dollars through inaccurate Medicare payments. The West Michigan Medicare Equity Coalition (WMMEC) represents multiple hospitals and health systems in the region that would have faced a near-catastrophic loss of Medicare funds had Section 508 not been implemented and subsequently extended. WMMEC has advocated for extension of Section 508 protection as well as implementation of an equitable long-term reform plan that will address the underlying problems with the AWI system. The coalition is pleased to provide the Ways & Means Committee Subcommittee on Health with the following testimony on the benefits of Section 508 and the need for equitable long-term AWI reform.

Background on AWI

The AWI exists to compensate hospitals fairly by addressing regional variations in labor costs associated with hiring and retaining high-quality nurses, technicians, and other staff. The system recognizes variations in labor markets and modifies federal Medicare payments accordingly so providers in higher cost regions that must pay higher labor costs receive indexes – and corresponding payments – that reflect these expenses. The index of each Metropolitan Statistical Area (MSA) is a ratio of that MSA's average hourly wage compared to the national average hourly wage, and the law requires the Center for Medicare & Medicaid Services to update the wage index annually using a number of financial inputs including hospital-specific cost data.

The law permits hospitals to petition CMS to reclassify to another MSA they believe is more representative of their true costs of doing business. According to a report to CMS by Acumen, LLC in April 2009, about one-third of all hospitals paid under the Inpatient Prospective Payment System (IPPS) have reclassification status. This statistic speaks strongly to the need for an overhaul of the system while retaining its mission of compensating hospitals fairly for market variations in the cost of labor. While WMMEC strongly supports implementation of an equitable long-term reform plan, we wish to address first the need for continuation of Section 508 protection, the item addressed during this hearing.

The Situation in West Michigan

In 1997, Butterworth Hospital and Blodgett Hospital in Grand Rapids merged to form Spectrum Health. As a condition of approving the merger, the United States District Court ordered the system to freeze wages for the first three years, 1997 to 1999, and to limit price increase for the four following years, 2000 to 2004. To comply with this directive, Spectrum Health froze staff

wages. During the same period, Congress enacted the Balanced Budget Amendment (BBA) that included Medicare provider cuts. The combination of the wage freeze and Medicare cuts created a "perfect storm" that sharply reduced the Grand Rapids MSA wage index from 1.0048 in Fiscal Year 2002 to .9548 in Fiscal Year 2003.

Section 508 protection provided our hospitals with a route to petition CMS and successfully reclassify to the Kalamazoo MSA, thus enabling us to receive an index that more closely reflects the region's labor costs. Since being enacted through the Medicare Modernization Act, **Section 508 has prevented the hospitals of West Michigan from losing more than $280 million in Medicare payments**. Most importantly, Section 508 protection has enabled the hospitals of West Michigan to expand and enhance care options for area patients while holding down costs. The latter has been particularly critical given the prolonged economic recession the state of Michigan is undergoing as it has prevented a host of undesirable consequences including layoffs, service reductions, and cost shifts to individuals and businesses. But because of the way in which indexes are calculated, the decline caused by the merger and BBA cuts would have a residual impact for years going forward, meaning the underlying problem remains uncorrected to this day. As a result, were Congress to not extend Section 508 protection, the hospitals of West Michigan would be saddled with the original problem and face the loss of tens of millions of dollars in Medicare funding.

A culture of Value

During this challenging financial climate, the hospitals of WMMEC wish to note the region's legacy of providing high-quality and lower-cost healthcare. According to the Dartmouth Atlas of Healthcare, Medicare reimbursements per-enrollee is nearly $900 less than the national average. This underscores that our hospitals take value seriously and take great care to limit costs while providing high-quality care. It is this concern for efficiencies that also drives our core principles for comprehensive AWI reform, a topic WMMEC remains committed to working with this committee to address.

Enacting Equitable Long-Term Reform

Twice over a little more than three years, in 2006 and in 2010, Congress has directed CMS and the Department of Health and Human Services to develop a long-term reform proposal. The first such effort resulted in no recommendation, and the second requires the Secretary of HHS to submit recommendations to Congress by the end of this year. To help shape this effort, WMMEC several years ago developed a core set of principles for reform, attached as Addendum A. Atop this list is the principle that reform must address concerns about efficiencies and not punish hospitals that hold down costs. Unfortunately, this tenet does not apply to the present system, meaning hospitals that pay higher wages are rewarded with higher indexes, creating the phenomena of "circularity" and only perpetuating the unsustainable cycle of high-costs.

A reformed AWI system must drive value-oriented reforms of our healthcare delivery system, notably the provision of efficient, high-quality, and patient-centered care. These reforms must not punish lower-cost providers by rewarding high-cost providers that overspend on labor costs. These reforms must reduce year-to-year volatility and reduce variation between neighboring

regions, particularly by reducing and eliminating "cliffs" from one region to another. And these reforms must also recognize the fundamentally unique operation that a hospital is and use transparent and auditable hospital-specific data to calculate wage indexes.

Conclusion

It is abundantly clear to all members of the West Michigan Medicare Equity Coalition that the AWI system must be reformed. But until this happens and an equitable reform plan can be implemented, Congress must maintain Section 508 protection. Failure to do so will resurrect the underlying problem and unjustly reduce Medicare payments to West Michigan hospitals by tens of millions of dollars. We urge the committee to protect beneficiary access to high-quality and low-cost care by maintaining this protection, and to redouble your efforts toward implementing an equitable long-term reform system. We thank the committee for providing us with this opportunity to submit testimony, and we look forward to working with the committee on both tasks.

Addendum A: WMMEC Principles for Long-Term AWI Reform

- **Reform should reflect growing concern about efficiencies.** With healthcare policymakers at all levels growing increasingly more concerned about achieving efficiencies within the healthcare setting, any long-term changes to this system should include this dimension. Unfortunately, under the current system, hospitals have a disincentive to be efficient because reduced cost results in lower indexes. Going forward, it is imperative that any AWI reform recognize the need to improve efficiencies and be non-punitive to those institutions which succeed in lowering costs.

- **Start with present wage indexes**. Considering the significant number of hospitals that are currently reclassified to other Metropolitan Statistical Areas (MSAs), a wholesale reversion to native AWI levels would result in significant economic harm to hospitals throughout the nation. Congress and CMS must recognize that current reclassifications have been appropriately assigned and are based on individual circumstances. As such, any AWI reform should begin by using nothing less than the area wage index assigned to each hospital as of September 30, 2007.

- **Gradual phase-in.** Any AWI reform will have a major impact on our nation's hospitals. As such, WMMEC strongly recommends that any reform package be phased in over an appropriate transition period. This phase-in period will enable all providers, especially those who will experience major changes under a reform proposal, to adjust to the changes.

- **Reduce volatility through annual "circuit breaker."** WMMEC also believes that longer-term reform is needed to produce less year-to-year volatility. As such, WMMEC recommends that any final proposal include a limit by which no hospital would see an annual reduction in its AWI of greater than 1.5 percent. This would help guard against extreme volatility and thereby diminish demand for reclassification.

- **Accurate data over a longer-time period.** Under the current system, a region that experiences an economic anomaly may end up being punished at least twice; once when the anomaly occurs and again, three years later, when the area wage index takes effect. This is simply not right, as all West Michigan hospitals can attest. We propose that any longer-term reform plan include a "rolling index" that consists of two years' worth of hospital data to help prevent such scenarios.

- **Ensure data reflects actual hospital employment challenges.** Hospitals are unique and highly specialized healthcare providers. They must provide state-of-the-art care around the clock. As such, hospitals find themselves competing against other hospitals for the qualified healthcare talent they need. To help ensure hospitals have the resources to attract and retain the best healthcare staff possible, it is critical that any longer-term reform recognize this business reality. Failure to do so, by including disparate professions and/or employers in the data set, will only make it more challenging for hospitals to fulfill their unique missions.

- **Smoothing data for more gradual changes when possible.** WMMEC supports the concept of creating a system with fewer dramatic shifts between adjoining statistical areas. This is part of the phenomenon experienced in West Michigan.

- **Maintain an appeal process.** WMMEC sympathizes with the desires of Congress and CMS to minimize the number of annual reclassification requests. Nonetheless, as MedPAC has noted, it is difficult to predict every individual scenario that may arise in crafting a new AWI model. While AWI reform may help reduce the number of appeals, it is essential that an appeal mechanism be retained in any new system. Simply put, hospitals must maintain the right to petition CMS if they believe evidence supports reclassification.

- **Integrity and Transparency of data.** Any AWI reform must allow the underlying data to be audited and verifiable as accurate. The sources and methodologies for compiling the data must be transparent. Together, these factors will help ensure the reliability of the AWI calculations.

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