HEARING WITH MEDPAC TO DISCUSS HOSPITAL PAYMENT ISSUES, RURAL HEALTH ISSUES, AND BENEFICIARY ACCESS TO CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

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HEARING WITH MEDPAC TO DISCUSS HOSPITAL PAYMENT ISSUES, RURAL HEALTH ISSUES, AND BENEFICIARY ACCESS TO CARE

WEDNESDAY, JULY 22, 2015

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

The Subcommittee met, pursuant to notice, at 10:06 a.m. in Room B–318, Rayburn House Office Building, the Honorable Kevin Brady [Chairman of the subcommittee] presiding.

[The advisory announcing the hearing follows:]

Chairman Brady Announces MedPAC Hearing

Congressman Kevin Brady (R-TX), Chairman of the Subcommittee on Health, today announced that the Subcommittee will hold a hearing with MedPAC to discuss hospital payment issues, rural health issues, and beneficiary access to care. **The hearing will take place on Wednesday, July 22, 2015 in Room B-318 of the Rayburn House Office Building, beginning at 10:00 A.M.**

Oral testimony at this hearing will be from the invited witness only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

Details for Submission of Written Comments:
Please Note: Any person(s) and/or organization(s) wishing to submit written comments 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 make a submission, 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, August 5 2015**. For questions, or if you encounter technical problems, please call (202) 225-3625 or (202) 225-2610.

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 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 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 submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.
2. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax

numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.
3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

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 at http://www.waysandmeans.house.gov/.

Chairman BRADY. Good morning. It is my pleasure to welcome Dr. Miller back to the Health Subcommittee to help us continue our discussion on payment reforms.

Earlier this year, Congress took the first step in this area and passed legislation to fix the way Medicare pays our nation's physicians. We did so in a broad, bipartisan, and bicameral way, and I was glad to see the President sign this important legislation into law.

Well, now we need to take the next step, and that means looking at Medicare's acute-care payment system. I want to raise the topic of site-neutral payment reforms. This is a policy MedPAC has highlighted for several years now. The President's most recent budget even included a site-neutral policy with respect to services provided in hospital outpatient departments. So this area of payment reform is not—or at least should not be—a new or contentious topic.

This year's June report brings us new information and data that could help elevate our discussion in this area.

MedPAC has found that, for some cases, we are paying as much as $4,000 more per case, simply because there is a discrepancy regarding status. That is, was the patient supposed to be classified for inpatient status or outpatient status? Unfortunately, this is a real question that hospitals are faced with.

But because the inpatient and outpatient payment systems are so different, it is hard to get an accurate assessment of what is driving this trend. More to the point, the codes that are used to determine what Medicare should pay for inpatient services are entirely different from those used for outpatient services. Not only does this mean hospitals are responsible for managing two different billing systems, but it means Medicare has to do the same.

And the issues with payment disparity become magnified when we consider that Medicare is expected to spend more than $130 billion on inpatient services, and $40 billion on outpatient services this year alone. Clearly, this is an area ripe for reform. MedPAC has proposed some innovative solutions; I look forward to hearing more today.

Also, MedPAC's testimony focuses on indirect medical education, and disproportionate share hospital payments, two add-on pay-

ments that certain hospitals receive to help offset the cost of teaching medical students or treating a larger volume of uninsured or under-insured patients. It is important to note that when we are talking about payment disparities between the inpatient and outpatient systems that these two add-ons, IME and DSH, are only included on the inpatient side. Outpatient discharges are not eligible to receive these payment adjustments. As a result, these important payments get caught up in a financial numbers game and end up driving incentives.

I believe both of these programs are critical and need to be designed to deliver the most targeted payments possible. As arbitrary add-on payments, they are not achieving their mission. As MedPAC notes in the June report, and as Medicare's own trustees tell us each year, the program is facing serious fiscal and demographic headwinds. Spending is out of control, and the current financial underpinnings will soon not be able to sustain the program for the long term. Congress needs to tackle these issues, and we need to tackle them now.

We have already started down this path by successfully reforming how Medicare pays our local doctors. My hope is that we can carry this progress over into other payment areas.

Chairman BRADY. With that, I would like to introduce today's witness, Mark Miller, the executive director of the Medicare Payment Advisory Commission, known as MedPAC. And before I recognize our Ranking Member, Dr. McDermott, for the purpose of an opening statement, I ask unanimous consent that all Members' written statements be included in the record.

[No response.]

Chairman BRADY. Without objection, so ordered. And I will recognize our Ranking Member, Dr. McDermott, for his opening statement.

Mr. MCDERMOTT. Thank you, Mr. Chairman, for holding this hearing today. I hope it will be a constructive conversation about how we can improve and strengthen Medicare.

I would like to thank our witness, Dr. Miller, for coming again today. We haven't seen you for a long time. We missed you, and we thought it was time to have a talk with you again.

The work that MedPAC does makes an invaluable contribution, really, to the legislative process. We may not always agree with the Commission's recommendations, but we can trust that MedPAC's reports are based on the facts, data, and thoughtful analysis.

Today's hearing is an excellent opportunity for the committee to carefully examine a number of issues that affect the future of the Medicare program. At the heart of the conversation must be the most important concern: that is, making sure that beneficiaries continue to have access to affordable, high-quality care. Any proposals that we discuss here, I think, should be seen through that lens. And any changes that we have to make have to be in the best interests of the beneficiaries.

Medicare is really about beneficiaries. It isn't about providers, it isn't about drug companies, it isn't about hospitals, it isn't about anybody else. It's really about beneficiaries. Medicare is a key component of the social safety net in the country. It provides core health care benefits to 54 million seniors and people with disabil-

ities. And I hope this Committee will join me in looking at ways to strengthen, not cut the program, to ensure that it remains strong in the future.

If we are looking to achieve savings, the first place we should look is to make sure that payments are appropriate and accurate. We should proceed with caution before radically cutting payments at the expense of hospitals that serve the most vulnerable patients, and the teaching hospitals that train the physician workforce.

As we discuss the potential policy issues today, it is important to remember that many are not formal recommendations by MedPAC. They are thought-provoking ideas that provide us with starting points for discussion. It is the role of the committee to carefully consider these ideas and ask tough questions about what they mean for Medicare and the beneficiaries.

I am hopeful that this hearing will serve as an opportunity for us to highlight a transformation that is radically shaping the health care system and practice of medicine. Across the country at this moment we are seeing a rapid and dramatic trend of hospitals merging together into massive health systems that exert tremendous market force. We count on our system to be working on the basis of competition, but it is increasingly questionable whether that occurs. We are witnessing hospitals purchasing small physicians' practices. As a consequence, more physicians are now hospital employees, something that was almost unthinkable when I went to medical school. This trend raises a question about the future of the medical profession, health care spending, and patient care.

As policymakers, our role is to ask these questions. The committee needs to hold a hearing on this issue and other topics related to health care consolidation. It is not a partisan issue, and I believe that we can work together to ask these questions and find out how to address this issue and move forward. And I hope this morning will be sort of a beginning.

So, welcome, Dr. Miller, to the committee.

Mr. MILLER. Thank you.

Chairman BRADY. Thank you, Dr. McDermott. And thank you, Dr. Miller. You are now recognized for five minutes.

STATEMENT OF MARK MILLER, EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. MILLER. Chairman Brady, Ranking Member McDermott, distinguished committee members, I am Mark Miller, executive director of the Medicare Payment Advisory Commission. On behalf of the commissioners, I would like to thank you for asking us to testify today.

The Commission's work in all instances is guided by three principles: to assure that beneficiaries have access to high-quality, coordinated care; to protect taxpayer dollars; and to pay providers in a way to accomplish these goals. I will start off today by reviewing some hospital trends.

Hospital inpatient admissions are declining, both in Medicare and among the privately insured population. This has been a trend for several years now, and it is fueled in part by movement of surgery from the inpatient to the outpatient setting. In contrast, serv-

ice volume in the outpatient setting has been increasing rapidly. For Medicare fee-for-service, the increase has been 33 percent over the last 7 years.

While it varies by market, overall there appears to be excess inpatient capacity in the country. Hospital occupancy rates are around 60 percent and have been declining. And in rural areas the occupancy rates are around 40 percent. This is an issue that will drive change in the near term. Regardless of whether a hospital is urban or rural, the focus of hospital care is changing from the inpatient setting to the outpatient setting.

Another fact of life is that the hospital industry has been consolidating for several decades now. Again, it varies by market, but many hospitals have very strong bargaining positions relative to private insurers. And, consequently, private insurers pay hospitals well above their cost, and much more than Medicare pays. On average, hospitals are paid 150 percent above their cost by private insurers. Our analysis has shown that these higher payment rates in turn results in higher costs. In other words, if a hospital is paid more by private insurers, all things considered, there are higher costs per admissions in that hospital.

One other trend that I believe all of you are aware of is that there has been a lot of activity by hospitals in purchasing physician practices [sic]. Some argue that this is to integrate and coordinate care. Others argue that this is to capture market share and increase revenue by obtaining higher outpatient hospital payment rates for office services.

Perhaps the most concerning version of this is where a hospital purchases a physician practice in the community, and then shifts the billing for those services from an office fee schedule to a hospital fee schedule. This means that insurers, private and Medicare, pay more, although very little has changed. And, of course, of most concern, the beneficiary has a higher copayment, as a result of this.

Turning to some of the Commission's recommendations, the Commission has recommended increasing Medicare's hospital payment rate, but coupled that with site-neutral payment reductions to remove some of the market distortions I just mentioned. To improve coordination, the Congress adopted the Commission's recommendation for a penalty on hospitals with excessive readmission rates. Readmission rates have fallen, but there is a further adjustment needed for hospitals that serve substantial numbers of the poor.

The Commission recommended retargeting the excess indirect medical education add-on payment to hospitals and other entities that administer reform graduate medical education programs that focus on care coordination, and provide training in alternative sites of care. The Institute of Medicine recently made a similar recommendation.

Most recently, the Commission has made a series of recommendations regarding the recovery audit contractors, to strike a balance between program integrity and administrative burden on hospitals. At the same time, the Commission made a set of recommendations to improve the protections for beneficiaries who are treated in observation status in the hospital.

With respect to rural care, the Commission has made a number of recommendations that have resulted in higher payments for

rural hospitals over the years. And, as a result, the 900 rural PPS hospitals have higher margins than those for urban hospitals. And, as you know, the remaining 1,300 rural critical access hospitals are paid on a cost basis.

The Commission undertook a comprehensive review of access, quality, and payment between urban and rural areas in 2012. In general, the Commission found that urban and rural Medicare beneficiaries have similar levels of health care use, satisfaction, and quality, although there are some important differences that should be discussed, if we get into that.

More importantly, the Commission strongly believes that there is a need for supports in rural areas, but that these supports are often not well targeted or designed. One principle for reform that I will mention here is that supports should be targeted to providers who have low patient volume, and are thus unable to cover their fixed cost, but serve as a vital source of access, meaning that they are distant from other providers. To put it simply, in short, targets should support low-volume, isolated providers.

In closing, I would like to thank you for asking the Commission to testify today. I look forward to your questions.

[The prepared statement of Mr. Miller follows:]

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Hospital policy issues

July 22, 2015

Statement of
Mark E. Miller, Ph.D.

Executive Director
Medicare Payment Advisory Commission

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

Chairman Brady, Ranking Member McDermott, distinguished Committee members. I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). The Commission appreciates the opportunity to discuss hospital payment issues with you today.

MedPAC is a small congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's work in all instances is guided by three principles: ensuring beneficiaries have access to high-quality, coordinated care; protecting taxpayer dollars; and paying providers and plans in a way that accomplishes these two goals.

The Commission has done extensive work on issues related to hospital payment policy. By law, each year the Commission is required to assess the adequacy of hospital payments and recommend payment updates for hospital inpatient and outpatient services. To evaluate whether aggregate payments are adequate, we consider beneficiaries' access to care, changes in the volume of services provided, hospitals' access to capital, quality of care, and the relationship of Medicare's payments to the average cost of caring for Medicare patients (a Medicare margin).

In addition to these annual payment adequacy assessments, over the years the Commission has examined several hospital payment policy issues. The goal of these analyses is to ensure that payments are accurate and equitable across different types of hospitals and across different types of hospital services. For example, at various points, the Commission has analyzed graduate medical education (GME) payments, disproportionate share hospital (DSH) payments, and rural hospital add-on payments to determine whether they are set at an empirically justified rate and are effectively targeted to achieve their policy goals. More recently, the Commission has looked at refinements to the hospital readmissions penalty, recovery audit contractor (RAC) reviews of short inpatient hospital stays, and whether payment rates for certain services are encouraging providers to shift these services to more costly sites of care.

In the testimony that follows, I will provide an overview of trends in the hospital sector and then describe a range of Commission recommendations to improve the accuracy of fee-for-service (FFS) hospital payment rates.

Background

In 2013, the 4,700 hospitals paid under the Medicare prospective payment systems and the critical access hospital payment system received $118 billion for 10.1 million Medicare inpatient admissions and nearly $49 billion for 196 million outpatient services. Medicare inpatient discharges declined 4.4 percent per Medicare FFS Part A beneficiary between 2012 and 2013 and fell by a total of about 17 percent from 2006 to 2013. Inpatient volume declined more rapidly in rural hospitals than urban hospitals. Between 2012 and 2013, the total number of rural hospitals' inpatient discharges declined 5.2 percent compared with a 2.3 percent decline in urban hospitals. Among privately insured individuals under age 65, inpatient discharges per capita declined by 3.5 percent in 2012 and another 2.7 percent in 2013 (Health Care Cost Institute 2014). This trend suggests that inpatient volumes declined for all insured patients through 2013, not just Medicare beneficiaries.

From 2012 to 2013, the use of outpatient services increased by 3.8 percent per Medicare FFS Part B beneficiary; over the past seven years, the cumulative increase was 33 percent. This growth in part reflects a secular shift in care from the inpatient setting, as well as the trend of hospitals purchasing freestanding physician practices and converting them into hospital outpatient departments (HOPDs). As hospitals do so, market share shifts from freestanding physician offices to HOPDs. From 2012 to 2013, hospital-based evaluation and management visits per beneficiary grew by 9.4 percent compared with 1.1 percent growth in physician-office-based visits. Other categories of services, such as echocardiograms and nuclear cardiology, are also shifting to the higher cost site of care. Among other effects, the shift in care setting increases Medicare program spending and beneficiary cost-sharing liability because Medicare payment rates for the same or similar services are generally higher in HOPDs than in freestanding offices.

The Commission's annual payment adequacy assessment has consistently found that there is adequate access to and supply of hospital beds. The average hospital occupancy rate declined from 64 percent to 60 percent between 2006 and 2013, suggesting excess capacity in many markets. In the 10 metropolitan areas with the lowest number of hospital beds per capita, the

average occupancy rate was 60 percent, compared with an average occupancy rate of 56 percent in the ten metropolitan areas with the highest number of beds per capita. There were 15 hospital openings and 25 hospital closures in 2013, resulting in a net decrease of approximately 1,000 hospital beds, a 0.1 percent reduction in existing bed capacity. Bed capacity is likely to continue declining, reflecting the continued decline in inpatient use and the corresponding rise in outpatient use. As mentioned, Medicare utilization of outpatient services increased 33 percent over the past seven years.

Turning to other payment adequacy factors, hospital quality is uneven but has improved. Hospitals spent $20 billion in capital expenditures, increased their employment, and generally have strong access to capital markets. However, hospitals' overall Medicare margin—a measure of the relationship between Medicare payments for, and hospitals' costs of, providing care to Medicare patients—is negative. In 2013, the median hospital margin was –5.4 percent. Relatively efficient hospitals (i.e., hospitals with lower costs and better quality over three years) had a median margin of 2 percent in 2013.

Part of the reason Medicare margins are low is that hospitals have high costs per case driven in part by lack of fiscal pressure from private payers. The Healthcare Cost Insitute reports that payment rates from private insurers have grown at an average of over 5 percent annually from 2011 through 2013. Commercial rates, on average, are about 50 percent higher than hospital costs and over 50 percent higher than Medicare rates. For example, Aetna and Blue Shield of California pay hospitals rates that are often 200 percent of Medicare's rate for inpatient care and 300 percent of Medicare's rate for outpatient services in California (California Department of Insurance 2014a, California Department of Insurance 2014b). In 2013, hospital all-payer margins were a record-high 7.2 percent.

The Commission has shown that higher payments from private insurers allow hospitals to have higher costs which, in turn, makes Medicare margins more likely to appear inadequate. There is evidence that higher private insurer payments result from hospital consolidation—that is, hospitals have gained greater market power relative to private insurers. When financial

resources are abundant hospitals spend more—increasing their number of inputs and cost per input. All else equal, higher costs per case result in lower Medicare margins.

Of course, hospitals vary in their circumstances. Some hospitals have market power, a higher percentage of private payer patients, and stronger revenue from investments and donations. These hospitals tend to have higher costs. Hospitals without these characteristics have lower costs. Put differently: hospitals with the most revenue have the highest costs per admission. For example, we found that hospitals with low private payer profits from 2008 to 2012 had a median standardized Medicare cost per case in 2013 that was about 9 percent less than the national median, and generated a median overall Medicare profit margin of 4 percent. In contrast, hospitals with high private payer profits over the same period had higher costs per case (3 percent above the national median) and lower Medicare margins (–9 percent). This analysis suggests that hospitals can constrain their costs, but the lack of pressure from private payers is discouraging them from doing so.

MedPAC's 2015 hospital recommendations

Based on its annual assessment of payment adequacy indicators, MedPAC recommended a package of hospital payment policy changes for 2016. The package included a payment update and two policies to equalize payment rates between different settings.

The update recommendation is higher than current law because payment adequacy indicators are largely positive, but Medicare margins are negative. One objective of the Commission's annual payment adequacy analysis is to recommend an appropriate aggregate level of payment through the update. The second objective is to recommend adjustments in payment policies to set appropriate relative prices across services and across sites of care. The two site neutral recommendations in the Commission's 2015 update recommendation package address this second objective.

One problem with the current system of relative prices is that differences in prices across care settings are causing distortions in provider incentives. For example, hospital outpatient

department rates are not aligned with rates paid for the same services in physicians' offices, giving hospitals an incentive to acquire physician practices and bill for the same services at outpatient rates, increasing costs to the program and to the beneficiary. To remove this incentive, we recommended setting outpatient rates equal to, or closer to, physician office rates for a set of services that are often performed in both locations.

A similar problem exists for hospital inpatient services. Long-term care hospitals (LTCHs) are currently paid much higher rates than traditional acute care hospitals (ACHs). Historically, there have been few criteria defining LTCHs, the level of care they provide, or the patients they treat. The Commission and others have repeatedly raised concerns that the lack of meaningful criteria for admission to LTCHs means that these providers can admit less-complex patients who could be cared for appropriately in less expensive settings. Comparatively attractive payment rates for LTCH care have resulted in an oversupply of LTCHs in some areas and may generate unwarranted use of LTCH services by patients who are not chronically, critically ill (CCI). To reduce incentives for LTCHs to admit lower acuity patients—who could be appropriately cared for in other settings at a lower cost to Medicare—the Commission recommended that standard LTCH payment rates be paid only for LTCH patients who are truly CCI. LTCH cases that are non-CCI should be paid at the appropriate inpatient prospective payment system (IPPS) rates. The Commission recommended that to meet the CCI criteria and qualify for LTCH payment rates, patients must have had a preceding stay in an intensive care unit (ICU) of at least eight days, or have received mechanical ventilation for 96 hours or more during an immediately preceding ACH stay. Congress implemented a version of this policy in the Pathway for SGR Reform Act of 2013, which defines patients with a preceding ICU stay of at least three days as appropriate for LTCH-level payment.

Special hospital add-on payments

Our analysis of payment adequacy addresses whether Medicare's aggregate payments to hospitals are sufficient, and whether payment rates are set appropriately across services and sites of care. The Commission also considers how well Medicare's inpatient payments are distributed among different types of hospitals, given that almost 15 percent of inpatient payments are made

in the form of three policy adjustments: indirect medical education (IME), disproportionate share hospital (DSH) payments, and uncompensated care payments. In addition to IME and DSH payments, Medicare has several payment programs designed to help rural hospitals. These include extra payments for rural referral, sole community, and Medicare-dependent hospitals (MDHs) within the IPPS and separate cost-based payment for critical access hospitals (CAHs).

IME and DSH payments

Indirect medical education (IME) payments are designed to support the higher costs of patient care associated with teaching. Based on a formula, IME payments are an adjustment—a percentage increase—to the amount Medicare pays for each admission to a teaching hospital. The amount of the IME add-on varies based on hospitals' "teaching intensity" (as measured by the ratio of residents to hospital beds). Therefore, hospitals' IME payments are tied to their Medicare inpatient volume and case mix, as well as the size of their residency programs (subject to their resident cap number). Medicare's IME payments totaled an estimated $6.5 billion in 2013, but repeated Commission analyses finds that only 40 percent to 45 percent of these payments can be analytically justified to cover the higher patient care costs of Medicare inpatients. In essence, the current adjustment is set at more than twice what can be empirically justified, resulting in over $3.5 billion directed to teaching hospitals with little accountability for their use of these funds. One argument that has been made for paying above the empirical cost is that the payment system does not adequately reflect the higher severity of patients treated in teaching hospitals. However, based on earlier Commission recommendations, payment system refinements were implemented in 2007 to better capture differences in patient severity. These changes increased payments to major teaching hospitals.

Similarly, the DSH adjustment has a weak relationship to the cost of treating low-income patients. The original justification for Medicare DSH payments was that poor Medicare patients were thought to be more expensive in ways that were not accounted for by the original DRG system. By 2011, both the Commission and other researchers concluded that, at most, 25 percent of the DSH payments were empirically justified by the higher costs at hospitals treating low-income Medicare patients. Therefore, hospitals that served high shares of poor Medicare patients

and Medicaid patients were given higher Medicare payments than were justified by the costs of their Medicare patients. In 2010, Congress enacted several changes to DSH payment policy in the Patient Protection and Affordable Care Act (PPACA). The pool of Medicare DSH dollars was divided into two pools: one available for traditional DSH and one for (non-Medicare) uncompensated care costs. Under PPACA changes, 25 percent of the old Medicare DSH pool is allocated for DSH payments, and the remaining 75 percent is designated for uncompensated care payments (the Commission has raised concerns about the measure used to allocate uncompensated care payments). The amount that is paid out for uncompensated care is set to decline as the national rate of uninsurance decreases.

Financing graduate medical education

Despite the tremendous advances our graduate medical education (GME) system has brought to modern health care, the Commission finds that it is not aligned with the delivery system reforms essential for increasing the value of health care in the United States. Two specific areas of concern are education and training in skills needed to improve the value of our health care delivery system (including evidence-based medicine, team-based care, care coordination, and shared decision making) and workforce mix (including trends in specialization and limited socioeconomic diversity). We cannot accomplish delivery system reform without simultaneously ensuring that our residency programs produce the providers and skills necessary to integrate care across settings, improve quality, and use resources efficiently.

The Commission has made five recommendations to the Congress to address these challenges. The broadest of these recommendations rests on two principles: decoupling Medicare payments for GME from Medicare's inpatient FFS payment system and ensuring that resources for GME are devoted to programs meeting high educational standards. The Commission recommends that approximately 60 percent of IME payments be awarded to hospitals and other entities that meet educational and program design criteria, instead of making these payments only to teaching hospitals through an inpatient add-on. Under this recommendation, the Secretary of Health and Human Services would consult with a range of organizations and individuals with the necessary expertise and perspectives to establish the desired standards—specifically, representatives from

organizations such as program-accrediting bodies, certifying boards, training programs, health care organizations, health care purchasers, and patient and consumer groups. From these deliberations, the Secretary would develop residency programs that encompass training in a range of settings in addition to the hospital, including offices, clinics, nursing homes, and rural locations, as well as developing a residency program curriculum that fosters the skills noted above, including team-based care. The Secretary's objective would be to create a GME payment system that fosters greater accountability for Medicare's dollars and rewards education and training that improves the value of our health care delivery system. Funding for this initiative would come from the amount that Medicare pays hospitals above their empirically justified costs for IME—currently estimated to be over $3.5 billion.

The remaining four recommendations:

1) Address concerns raised by the graduate education community that Medicare resources are not being used for educational purposes by making the amount of Medicare resources being paid to teaching hospitals more transparent;
2) Call for an objective analysis of workforce needs based on reformed care delivery and better organization of responsibilities among physicians and other health care professionals in lieu of increases in the number of Medicare subsidized slots based on simplistic straight line projections of workforce needs;
3) Call for analyses to understand the value of different specialty residency programs to hospitals to better support future discussions of Medicare's GME subsidies across specialties; and
4) Call for an examination of a range of Department of Health and Human Services programs designed to increase the racial, ethnic, socioeconomic, and rural diversity of the medical school population.

Rural hospital add-on payments

A key objective of Medicare's rural payment adjustments is to maintain access to care. Areas with low population density may have small, isolated, low-volume care providers. In these cases,

costs may be above average because the low population density prevents economies of scale, and the low volume and high costs may be beyond a provider's control. Special payments by federal or local sources may be needed to maintain access to care in these communities. However, in some cases, the special payments are not well targeted to address access.

Rural hospital background

In its June 2012 report, the Commission examined rural Medicare beneficiaries' access to care, rural providers' quality of care, special rural Medicare payments, and the adequacy of Medicare payments to rural providers. Rural and urban areas have comparable levels of inpatient and physician utilization. They also have generally comparable levels of post-acute care use, though post-acute care utilization is somewhat lower in frontier areas. Both urban and rural beneficiaries report high levels of satisfaction with their access to care.

The Commission also found similar levels of quality among rural and urban settings, particularly in the post-acute care setting. However, the Commission did find differences in quality of care between urban and rural hospitals. Smaller rural hospitals do not perform as well as urban hospitals on most process measures and on condition-specific 30-day mortality rates. The Commission's analysis of 2010 Medicare data is consistent with other findings in the literature over the past 20 years (Joynt et al. 2011, Keeler et al. 1992).

The Commission found that the adequacy of payments to rural hospitals has improved over time, in part due to the creation of special add-on payments to support these providers. In 2001, when rural hospitals' inpatient profit margins were below urban hospitals' profit margins, the Commission concluded that Medicare payment rules favored large urban hospitals. As a result, the Commission recommended increasing rural hospitals' base payment rates to the rates paid to large urban hospitals, increasing rural disproportionate share payments, and implementing a low-volume adjustment for isolated rural providers serving areas with low population density that lack economies of scale. The Congress enacted legislation consistent with the Commission's recommendations by 2004 and then endorsed a series of other changes that further increased

rural hospital payments. These changes to the hospital prospective payment system, along with expansion of the CAH program, have improved rural hospitals' financial stability significantly. The 860 rural IPPS hospitals have higher Medicare margins than urban hospitals on average, and the 1,300 CAH hospitals are paid based on their Medicare costs.

Principles for evaluating rural add-on payments

One challenge for policymakers is that the current mix of rural payment adjusters is not guided by a coherent set of underlying principles. The adjusters evolved separately, and there is not a clear common framework for how they are intended to work together to preserve access without duplicative, overlapping adjustments. In addition, they are not always targeted to the areas with the greatest concerns about access to care. The lack of targeting stems in part from Medicare's definition of "rural." Medicare defines rural as all areas outside of metropolitan statistical areas, so many adjustments can apply to rural areas with a single local provider, as well as rural areas with many competing local providers. The Commission has created a framework of principles for rationalizing rural add-on payments that includes targeting providers that are necessary for access, empirically justifying (and not duplicating) payments, and maintaining incentives for cost control.

Principle: Target payment adjusters to low-volume, isolated providers to preserve access

Payment adjusters should be targeted to providers that are necessary to preserve beneficiaries' access to care. Generally this means that Medicare's special supports should go to providers who are located in low population density areas and are distant enough from other providers to serve as a vital source of care. Currently, special adjustments often go to rural providers located in close proximity to other rural providers. For example, 16 percent of CAH hospitals and 9 percent of sole community hospitals are located within 15 miles of another hospital.

Many of the current adjustments focus on increasing payments to low-volume providers. However, there are two types of low-volume providers. One type is isolated providers who have low volumes because of low population density in their markets. These providers often have difficulty covering their fixed costs given their low volume of cases. For these providers, low

volumes are inevitable and beyond their control. A second type of provider has low volumes because neighboring competitors attract patients away from the low-volume provider. These providers are not necessary for access, and it may be inappropriate to give a low-volume adjustment to two competing low-volume hospitals that are 5 or 10 miles from each other. By focusing low-volume adjustments on isolated providers, rather than making the adjustment available to all providers with low volumes, Medicare can best use its limited resources to serve Medicare beneficiaries. Such a policy may also encourage two nearby hospitals to merge, increasing patient volumes.

Principle: Empirically justify the magnitude of payment adjustments

The magnitude of the adjustment should be determined empirically. For example, it is necessary to determine the degree to which a low patient volume makes it more difficult for a provider to cover its fixed costs. Patient volume should be measured as total patient volume rather than solely Medicare patient volume, because economies of scale depend on total volumes of patients.

Principle: Maintain incentives for cost control

It matters not only how much money is paid to rural providers, but also how it is paid. For example, Medicare's approach of paying prospective payment rates to providers puts stronger pressure on providers to control their costs. Cost-based payments reduce this incentive. Therefore, cost-based reimbursement could be limited to the most isolated providers with very low case volume and highly variable costs that are hard to predict.

Principle: Set equal quality expectations for nonemergency services, but recognize that emergency services may need to be subject to different quality standards

Expectations for quality of care in rural and urban areas should be equal for nonemergency services that rural providers choose to deliver. That is, if a provider has made a discretionary decision to provide a service, that provider should be held to a common standard of quality for that service, whether the service is provided in an urban or a rural location. Emergency services may be subject to different quality standards to account for different levels of staff, patient volume, and technology between urban and rural areas.

Refining the hospital readmissions penalty

Noting high hospital readmission rates (around 19 percent) and little improvement in these rates over time, the Commission recommended a penalty for hospitals with relatively high readmissions rates. Congress subsequently enacted a hospital readmission reduction program (HRRP) in 2010. Since the introduction of the penalty, readmission rates have fallen for Medicare beneficiaries across all types of hospitals. In 2013 Medicare beneficiaries experienced roughly 100,000 fewer readmissions than in 2012.

Given the positive effects of the penalty, the Commission believes that the policy should be continued, and has recommended expanding readmissions penalties into several post-acute care sectors. However, the calculation of readmissions rates and penalties could be refined to address three issues with the current policy.

- Under current policy, aggregate penalties remain constant when national readmission rates decline. This means that some providers will always be penalized, even if the entire sector improves its readmissions rate substantially. Instead, the Commission would set a fixed target for readmission rates. Penalties would go down when industry performance improves.
- In 2015, the HRRP covers five conditions (heart failure, acute myocardial infarction, (AMI), pneumonia, chronic obstructive pulmonary disease (COPD), and planned hip and knee replacement surgery). Single-condition readmission rates face significant random variation due to small numbers of observations. Instead, the Commission would use an all-condition readmission measure to increase the number of observations and reduce random variation.
- Hospitals' readmission rates and penalties are positively correlated with their low-income patient share. To avoid unfairly penalizing hospitals that treat large shares of low-income patients, the Commission would evaluate hospital readmission rates against a group of peers with a similar share of poor Medicare beneficiaries. Each peer group would have its own target readmissions rates, meaning hospitals with

higher shares of poor patients would have an easier target rate than hospitals with lower shares of poor patients. Though penalties would be adjusted to account for socioeconomic status, Medicare would continue to report an unadjusted readmissions measure to avoid masking disparities and reducing pressure to improve care for low-income patients.

Hospital short-stay issues

Since the implementation of the IPPS, payment incentives along with changes in technology and medical practice patterns have substantially shortened hospitals' average inpatient lengths of stay, allowing many inpatient services to successfully migrate to the outpatient setting. As a result, the issue of whether a patient requires inpatient care or could instead be treated safely as an outpatient has received increasing attention. Because hospitals generally receive higher payments for clinically similar patients served in the inpatient setting as compared with the outpatient setting, hospitals may have a financial incentive to admit patients.

Created by the Congress and implemented nationwide in 2010, Medicare recovery audit contractors (RACs) have targeted short inpatient stays in their audit efforts, resulting in denials of these claims on the grounds that the patients' status as an inpatient was not appropriate. Hospitals have appealed many of the RACs' claims decisions, but have expressed concern about the cost of pursuing appeals, large backlogs in the appeals process, and limited options for rebilling denied inpatient claims as outpatient claims.

In reaction to the heightened scrutiny of short inpatient stays, hospitals have increased their use of outpatient observation status. Greater use of outpatient observation status, in turn, has caused concern about beneficiaries' financial liability. While Medicare cost sharing for outpatient observation services is typically less than the inpatient deductible, for a subset of beneficiaries, the greater use of outpatient observation status has increased the likelihood that they will not qualify for Medicare coverage of post-acute skilled nursing facility (SNF) services (which requires a preceding three-day hospital inpatient stay). Beneficiaries in observation status may

also be liable for hospital charges related to self-administered prescription drugs received in the hospital and not covered by the Medicare outpatient prospective payment system (OPPS).

In an effort to clarify admission appropriateness and alleviate concerns about increased use of observation and its impact on beneficiary liability, as well as hospitals' concerns about RAC audits, CMS established the "two-midnight rule" in 2014. This rule stipulates that for hospital stays spanning two or more midnights (including time spent in the inpatient and outpatient settings), RACs should presume these stays are appropriate for the inpatient setting and are exempt from audit. By contrast, stays of less than two midnights remain subject to audit. The two-midnight rule has been controversial, and its enforcement has been delayed by both CMS and the Congress.

Short-stay policy recommendations

In response to these issues, the Commission has developed a set of recommendations designed to provide greater protections for beneficiaries and reduce administrative burden for hospitals while ensuring that the program is not paying too much for hospital care. Several of these recommendations provide guidance on refining and targeting the RAC program. The remaining recommendations seek to reduce the financial burden that beneficiaries may face from hospitals' increased use of outpatient observation status.

Recommendations to improve hospital oversight

The Commission has recommended to the Secretary a package of policies to improve the RAC program. First, the Commission recommended targeting RAC audits to hospitals with the highest rates of short inpatient stays. Currently, RACs are auditing short inpatient stays broadly, across all hospitals. A more targeted policy would focus auditing efforts on hospitals with aberrant patterns of short inpatient stays, while reducing administrative burden for hospitals using short inpatient stays appropriately.

Second, the Commission recommended adjusting RACs' contingency fees based on their performance to make RACs more accountable for their decisions to deny hospitals' claims for

short stays. The contingency fee structure of the RAC program provides an incentive for the RACs to identify as many inappropriate claims and recover as much Medicare payment as possible. RACs lose payment if their denials are overturned, but face no further penalties for overturned denials and are not required to pay interest on the returned fee.

Third, the Commission recommended realigning the RAC look-back period and the Medicare rebilling window because the timing of the RAC program claim denial process and the timing of the Medicare rebilling policy are not coordinated. Currently, RACs are permitted to review claims that are up to three years old (from the date of service on the claim), while Medicare's rebilling policy allows hospitals only one year after a denied claim's date of service to resubmit a claim for the outpatient services included on the original claim. The Commission believes the Medicare program should align hospitals' ability to rebill RAC-denied claims because 1) a service was provided to a Medicare beneficiary and the hospital should receive reimbursement for it, and 2) alignment may reduce the number of appeals. However, the alignment between the look-back period and the rebilling period should strike a balance. It should reimburse a hospital for the outpatient service provided when an inpatient claim is denied but it should not allow hospitals to appeal all denied claims and still collect outpatient payments. The balance should encourage hospitals to pursue appeals for only those admissions for which the medical record presents strong evidence for the admission.

Finally, the Commission recommended the withdrawal of the two-midnight rule because, while the rule addresses some of its stated goals, it also eliminates RAC oversight for a large group of inpatient claims. Withdrawing the two-midnight rule, in conjunction with implementing the Commission's other audit-related recommendations, would be a better way to address the concerns associated with hospital short stays.

Concurrent with the RAC-related policies described above, the Commission has discussed the concept of a payment penalty on hospitals with excessive numbers of short inpatient stays to improve the efficiency of program oversight. The Commission believes that this concept warrants further evaluation and recommended that the Secretary evaluate a penalty on hospitals

with excess rates of short inpatient stays to substitute, in whole or in part, for RAC review of short inpatient stays.

Recommendations to reduce beneficiary liability

Hospitals' increased use of observation status has led to greater financial liabilities for certain beneficiaries. The Commission has made three recommendations to address this issue. First, the Commission recommended that the Congress revise the skilled nursing facility three-inpatient-day hospital eligibility requirement to allow up to two outpatient observation days to count toward meeting the criterion. By statute, in order to qualify for Medicare SNF coverage a beneficiary must have been an inpatient of a hospital for at least three consecutive calendar inpatient days preceding the SNF admission. Beneficiaries served in observation status and subsequently discharged to a SNF are therefore liable for the entire cost of their SNF stay. The Commission's recommendation would permit time spent in outpatient observation status to count toward the three-day prior hospitalization threshold, but would require that at least one of the three days be an inpatient day. This recommendation seeks to balance reducing beneficiary liability for cases that currently do not qualify for SNF coverage with protecting the taxpayer and maintaining the SNF benefit as a post-acute care benefit.

The Commission recommended that the Congress require acute care hospitals to provide beneficiaries in outpatient observation status with a timely notification that their observation status may affect their financial liability for SNF care. Beneficiaries served in observation status often do not realize that they have not been officially admitted to the hospital as an inpatient, and are often unclear about how it may affect their financial liability for SNF care or other services they receive while in the hospital. The policy should apply to beneficiaries who have been in observation for more than 24 hours and who are expected to need SNF care.

Beneficiaries who receive care in a hospital outpatient department may face an additional liability for self-administered drugs, such as daily oral medications taken by the beneficiary at home. These drugs are covered by Medicare Part A for hospital inpatients, but are generally not covered by Medicare Part B for hospital outpatients. Patients in outpatient observation, who tend

to have longer stays than other beneficiaries treated under outpatient status, are more likely to encounter this problem. Among the two-thirds of hospitals reporting SAD charges, about 75 percent of observation claims included charges for SADs. These claims had average drug charges of $209 per claim, relative to an estimated average cost of only $43 per claim. The Commission recommended packaging self-administered drugs during outpatient observation (on a budget neutral basis) to protect beneficiaries from paying full hospital charges for self-administered drugs, which are typically substantially above the cost of the drug.

Payment policy approaches to hospital short stays

The substantial payment difference between similar inpatient and outpatient stays creates a financial incentive for hospitals to admit patients to inpatient status. One way to reduce this financial incentive and ensure that admissions decisions are being made on a purely clinical basis is to reduce payment differences for similar stays in the inpatient and outpatient settings. The Commission explored two payment policy approaches to lessen payment differences between similar inpatient and outpatient stays. Under the first approach, Medicare could create—as part of its inpatient payment system—a new set of Medicare severity–diagnosis related groups specifically designed for inpatient one-day hospital stays. Under the second approach, Medicare could develop a site-neutral payment—that is, equalize payments across settings—for similar short inpatient and outpatient stays.

Under a one-day-stay DRG policy, Medicare would pay less for one-day inpatient stays and more for longer inpatient stays than it currently does. This would lessen the payment differential between a one-day inpatient stay and similar outpatient stay. However, one caution is that a one-day-stay DRG policy would create a new payment differential between a one-day inpatient stay and longer inpatient stays. A one-day-stay DRG policy would reduce the financial incentive to admit a patient for one-day inpatient stays, but it would create a financial incentive to extend an inpatient stay from one to two days.

Alternatively, a site-neutral approach would pay comparable rates for similar inpatient and outpatient stays. The effect of a site-neutral approach may be different for medical and surgical

hospital stays. For medical stays, it would be difficult to eliminate the inpatient and outpatient payment differential without creating new vulnerabilities because identifying similar stays would likely necessitate establishing length-of-stay criteria. Because surgery is a more clearly defined service, it might be possible to develop site-neutral payment for similar inpatient and outpatient surgeries without creating payment differentials based on length of stay.

Payment policy changes such as one-day-stay DRGs and site-neutral payment for medical stays would involve trade-offs. On the one hand, revising the payment system may reduce the need to audit one-day inpatient stays for admission appropriateness because the financial consequences related to the admission decision would be reduced. On the other hand, a revised payment system would create new payment cliffs and associated vulnerabilities, and therefore may simply shift the focus of audit oversight. Moving away from the fixed inpatient DRG payments to one-day-stay DRGs or site-neutral payment for medical stays also raises concerns about creating financial incentives for longer stays, which is counter to the original structure and intent of the DRG system. Given the competing arguments, the Commission has not made any recommendations to pursue payment changes at this time, but it has noted interest in continuing to explore these and other potential short-stay payment policy concepts in the future.

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Chairman BRADY. Doctor, thank you very much. Clearly, our goal is to save Medicare for the long term. And to do that we have got to get the incentives right, both for providing high-quality care to patients, affordability for our seniors, and to make sure this important program is around for a long time in the future.

I found it striking that MedPAC concluded that Medicare paid roughly $4,240 more, on average, for an inpatient stay than for a comparable outpatient surgery. This sounds like a good place for Congress to start establishing site-neutral payment. I hope you agree with that.

Mr. MILLER. It is certainly an area that should be looked at. It is one that we have begun to look at.

Chairman BRADY. You know, focusing on just the 10 surgical DRGs, or the procedures, like MedPAC did, how difficult would it be for Congress to craft a policy—and, obviously, what we are looking for is providing appropriate care at the appropriate setting for the appropriate price, and not creating incentives for people to get moved into higher costs, procedures, or areas, when we could do it in a neutral approach.

Mr. MILLER. I think that there is probably two ways to—or two ways to think about responding to that. One is whether there is the ability to kind of crosswalk between sets of services in the settings, so that you could create relatively comparable classifications of services, and actually focus on this is the service and set payments around that. And that, while it has a complexity to it, is probably something that could be done. And we could talk more about that. What I think——

Chairman BRADY. And a crosswalk is what, exactly?

Mr. MILLER. So it was what you were saying in your opening statement. You were talking about the notion that there were different systems and different codes, and that is why I was trying to bring it back to that. There are different systems and different codes, but you can probably work, you know, a crosswalk across that to begin to look at comparable, you know, groupings of services, or overlapping services. And the number that you are referring to in our report is a pass through, you know, the top 10 medical and the top 10 surgical services, where we try to do that.

But what I do also want to say, just by way of, you know, of caution, is what is more difficult to comment on is the actual structure of the policy. So if you try and say, "I am going to set up a site-neutral policy, where you have some services paid outpatient, some inpatient, and then some paid site-neutral," that is certainly a goal that you can move towards. But what will be key is how services get in and out of those three systems, and how, in a sense, you police the borders, if you will, when a service gets into one setting versus another.

And so, that would be the kind of issues that you would have to think through, and not inadvertently create other incentives that drive services in one direction or another.

Chairman BRADY. Just sort of proven out, the crosswalk, we think, is very important. We have gotten some pushback that that is difficult to do. I think—how difficult do you think it would be for CMS if we focused on these 10, you know, where you have identified them?

Mr. MILLER. Yes, and I don't want to toss this off as simple, but I—you know, I decidedly think it is doable. These things—there are, you know, proprietary products that exist in nature. They do somewhat different things, so reasonable people can kind of end up with somewhat different categorizations.

And so, there is some issues there that need to be smoothed through. And probably what you want, you know, if you were to ask CMS to do this, you would want, after they develop the crosswalk, you would want a clinical scrub, to make sure that you have some coherency in the categories that you created from a clinician's point of view—does this make sense to a physician?

Chairman BRADY. Sure.

Mr. MILLER. Nurse practitioner, that type of thing. And then, you know, you put it out for notice and comment.

But, you know, my sense is that the intellectual technology to do the crosswalking exists.

Chairman BRADY. Yes. One of the areas of reforms, obviously, inpatient/outpatient, are tremendously complicated. They are, in some sense, a demolition derby of reimbursements and incentives. The June Report, again, looking at these surgical procedures, June Report mentioned, really, two approaches: one, the site-neutral payment for these surgeries could be carved out of the inpatient/outpatient system and moved into a separate one; secondly, surgeries calling for site-neutral could be subsumed under the inpatient payment system.

These are two approaches we ought to be looking at. We included one of them in our draft last November on hospital reforms. Can you lay out sort of for the subcommittee what you see, the pros and cons of that? A separate system for those, or moving them under an inpatient?

Mr. MILLER. Okay. So—and I want to just do one thing quickly before I answer your question. You know, the way the Commission went at this was we were responding to kind of the two-midnight rule and a lot of the reaction to that, and a lot of concern on the part of the committees, and so forth, of what to do there. And the Commission ended up making recommendations on RACs and beneficiary protections, and talked about the payment stuff, but have not made recommendations on that yet. So I want to be real clear.

Chairman BRADY. Got it.

Mr. MILLER. We are talking about, you know, ideas, not policies, and not recommendations.

I think one thing to think through is the reason that you want to do these types of things is that your need for oversight, RAC types of overview, becomes less. To the extent that you make payments more comparable, there is less incentives to push a patient in one direction or another. So, to the extent that you are setting out and saying, "I want to set up payments so that this incentive is not so clear," that is one of the benefits of it. You are making decisions for clinical reasons, as opposed to financial reasons, and you may not have to have so much oversight.

The risk—and I already said it, so I will try and be very abbreviated—is how you set those boundaries and what services, whether the services are well-defined or bluntly subject to gaming, de-

pends on, you know—that is the risk you run when you try and set something up like this.

If you do it inside one of the existing systems—because your other question was what if I did some site-neutral stuff inside inpatient, or I did some site-neutral stuff in kind of a stand-alone system—my sense is, particularly if you are talking about a small set of services or conditions, or whatever we are talking about here, is you probably have less churning and change if you put it inside at one of the existing systems.

But I got to tell you, I am talking right off the top of my head, here. I would have to—want to think about this a lot more. Just saying that part——

Chairman BRADY. Yes, good. Finish with this question. We talked about a bit, both in the opening statement and yours, there is a gradual migration services from inpatient to outpatient. We need to recognize that. So we are concerned that this means, for our policies and payments associated with that, such as indirect medical education and DSH, it has an impact.

So, our goal is to preserve and protect these funds. I am concerned that they are not protected when they are so dependent on just one area, inpatient admission. One strategy I think Congress can pursue is reimburse indirect medical education and DSH in a lump-sum payment, rather than as a per-discharge add-on. So what do you think of this approach, how it might preserve and protect IME and DSH goals?

Mr. MILLER. I want to be really clear. This precise idea, or this precise notion, is not something that the Commission has talked about. And at the end of my answer I am going to tell you one thing the Commission has talked about.

But to try and answer your question first, I think I understand your instinct. I think your instinct is what you are saying is—if you are tied to inpatient, and inpatient is going down, how do you preserve that, I think, if that is what you are saying. And, to the extent you were to capture that, and assign that dollar to a hospital, in theory, movements in volume up or down or in or out would make that a more stable—regardless of movement, it would make that a more stable payment, all things considered.

I would also think if you were to say that is the direction you would go, I am sure the Commission would also say, "You want to think about, like, maintenance of effort types of things." If you get the block of dollars, you don't just back out of the teaching function, and that type of thing. But I assume, you know, if you are thinking about these kinds of things, you would be thinking about that.

Now, the one thing I do have to say is the Commission went in a different direction on this, and said there is $3.5 billion in direct medical education payments that are not well accounted for, and the Commission said, "Take that as a lump sum," but it was payable to hospitals or other entities that created these new programs. So, in a sense, we went in a somewhat different direction here from your idea.

Chairman BRADY. Well, I am not so sure we aren't going in that direction——

Mr. MILLER. Well——

Chairman BRADY [continuing]. As well, to be honest.

Mr. MILLER. Well, that is——

Chairman BRADY. Because I think we need a better—one thing, this is a bipartisan issue. How do we make sure we have the right training, the—for more doctors and future doctors? And we are intent on getting a much better insight into how all this is funded, and the results of that funding, going forward. So, Doctor, thank you very much.

Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I read your report, and over half of it is drug policy. About 100 pages are——

Mr. MILLER. June Report, yes.

Mr. MCDERMOTT. And it is interesting we are focusing on hospitals, because I think drugs—we recently passed a bill out of here called—the 21st Century Cures Act was passed out of the House. It didn't come through this commission—this Committee. But it had a provision in there that gave incentives to hospitals for the overuse of newer antibiotics.

And my question was did they come to you and talk to you about that? Did the Energy and Commerce Committee come to you?

Mr. MILLER. Not specifically, that I remember.

Mr. MCDERMOTT. It seems like it is going to——

Mr. MILLER. I am not sure I have got the provision well squared away in my head, just to be——

Mr. MCDERMOTT. Well, they are saying, "Use these new antibiotics, as opposed to the traditional antibiotics," there would be an incentive if you used the new antibiotics. Obviously, more expensive and better for the pharmaceutical industry, but I am not sure it doesn't drive up costs in hospitals.

Mr. MILLER. And I am just not wired enough on the specific——

Mr. MCDERMOTT. Okay, all right.

Mr. MILLER [continuing]. Provision to help you.

Mr. MCDERMOTT. That is fair enough. The issue that got you here—that is, the two-night, or the midnight, two-night—midnight business and all that—do you think you can find a site-neutral payment system that will not disadvantage the patients?

Mr. MILLER. And just to kind of try and pick up the thread here in my own mind, you know, the Commission approached the two-midnight issue, and ended up with a set of recommendations on RAC and beneficiaries, and ultimately didn't make recommendations on payment, and didn't feel that there was a necessity at that moment to deal with a—you know, the RAC, and the backlog issues through a payment change.

Your question is a little bit different, perhaps. But can you create a site-neutral payment that is fair to the beneficiary? I think it is all in the design of the policy, so I would say it is possible. Not this site-neutral conversation, but the Commission has made recommendations in—on other site-neutral policies between the physician setting and the outpatient setting. We actually think that helps the beneficiary, because it keeps their copayments down. In fact, it was one of the motivations for it.

Now, here, in this—pushing together inpatient and outpatient, it would probably depend on what services and how you defined the

actual thing, as to what the effect on the beneficiary's out-of-pocket would be. It would be very hard for me to comment, without knowing "the thing."

Mr. MCDERMOTT. We are talking theoretically here. Do you think you then could design a policy that a doctor and a hospital wouldn't look at and say, "Hey, let's do this, because that will qualify for this," which is a higher payment than that which is not a higher payment?

Mr. MILLER. And what I have tried to say and respond to a couple of questions that have occurred so far is that is the trick, is, you know—right now there is an incentive between the inpatient and outpatient settings that look like this. And if I can get into the inpatient, and I can keep the inpatient for one day—or keep the patient for one day, that is a very, you know, profitable transaction. I think you——

Mr. MCDERMOTT. Let me stop you right there.

Mr. MILLER. All right.

Mr. MCDERMOTT. Okay, it is transaction good for the hospitals.

Mr. MILLER. Yes.

Mr. MCDERMOTT. What about the beneficiary?

Mr. MILLER. So it depends on whether the beneficiary—so, generally, the beneficiary's out of pocket is less in outpatient than it is in inpatient. If you jump the inpatient wall, you pay $1,000, $1,200 deductible. If you are staying in the outpatient, in general, the beneficiary's liability is less.

However, if it is surgery, it is actually not as much difference. So it really kind of depends on—and this is why I am saying which services and what you do with them. And I think part of the reason the Commission said, "If you started thinking about surgery"—I mean thinking about site-neutral here, you might start with thinking about surgery, because the event is pretty definable, it is harder to game. And the differences in the copayments may not be as much.

Mr. MCDERMOTT. You are talking, therefore, about a patient who comes in with what looks like appendicitis, and they put him in observation, and they ultimately wind up becoming an operation for removal of the appendix. That is one kind. But the other kind of case would be somebody who has a pain in their chest, and they put him in for observation, and they never graduate to full-fledged ICU or cardiac surgery, or whatever.

Mr. MILLER. And just to take that point and just put it a little bit differently——

Chairman BRADY. Dr. Miller, could you do me a favor? Pull that microphone just a little closer to you.

Mr. MILLER. I am really sorry about that. So nobody has heard anything I said up to this point?

[Laughter.]

Mr. MCDERMOTT. I have been listening.

Mr. MILLER. Okay. All right. So now I have no idea what is going on.

[Laughter.]

Mr. MILLER. So, just to pick up on the thread of your question—I apologize, I didn't realize that was going on—the—one of the

things that the Commission did think about was whether we were talking about this kind of idea for medical or for surgical.

For—and I am not a physician, so I apologize for everything that is about to happen. For a medical condition, it is more complex to kind of follow what is going to—it can be more complex—on what is going to happen with the patient. You know, your point. Chest pain, I have chest pain, I have a heart attack, you know, these types of things can be relatively fluid, as opposed to surgery, where the event and the procedure and the thing that is going to happen to the patient is more well-defined, and most of the cost is very present in that event. And I think that is why the Commission thought, if you start something, start looking there.

Does that answer your question, or am I—now you are sorry I moved this close to me, right?

[Laughter.]

Mr. MCDERMOTT. Well, I—my feeling, then, is what happens to the patient at that point? Does he or she wind up more out of pocket?

Mr. MILLER. And I think that really depends on the service. But in a surgical situation—and I don't want to speak too globally on this, because the Commission really sort of looked at this, but didn't dive as, you know, deep on it. Generally between, you know—for over—surgeries that tend to overlap settings, the beneficiary's liability is more comparable between the inpatient and outpatient setting than the liabilities for a medical procedure.

Mr. MCDERMOTT. Can I have just a second to ask unanimous consent to drop in a letter from the American Hospital Association dated July 22nd?

[No response.]

Mr. MCDERMOTT. It is their——

Chairman BRADY. Without objection.

Mr. MCDERMOTT [continuing]. This Committee.

[The information follows:]

American Hospital Association

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

Statement

of the

American Hospital Association

before the

Health Subcommittee

of the

Committee on Ways and Means

of the

U.S. House of Representatives

"Medicare Payment Advisory Commission Hospital Policy Issues Hearing"

July 22, 2015

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment for the record on recent Medicare Payment Advisory Commission (MedPAC) hospital policy recommendations to Congress. The issues raised in their reports are of great interest to our member hospitals and health systems and the communities they serve.

HOSPITAL SHORT-STAY POLICY ISSUES

In its June report, the commission made several recommendations regarding hospital short inpatient stay issues, including that the Centers for Medicare & Medicaid Services (CMS) withdraw its two-midnight policy. **The AHA appreciates the commission's willingness to tackle this complicated set of issues and believes that it has the opportunity to make significant policy recommendations in this area. We support some of the recommendations but have concerns that others would not achieve the commission's articulated goals.**

If the two-midnight policy is withdrawn, hospitals would no longer be required to follow this arbitrary time-based benchmark. Hospitals also would lose the certainty of an inpatient payment for a stay spanning at least two midnights, and be subject to the overzealous audits of the recovery audit contractors (RACs). Currently, the AHA is gathering feedback from our members related to MedPAC's recommendation that CMS withdraw its two-midnight policy.

In addition, CMS recently proposed changes to the two-midnight rule in the calendar year (CY) 2016 hospital outpatient prospective payment system (PPS) proposed rule. We are reviewing this proposal closely; however, our initial perspective is that the proposed changes are a good first step. For example, the nation's hospitals appreciate CMS's proposal to maintain the certainty that patient stays of two midnights or longer are appropriate as inpatient cases. We also agree with CMS's proposal that stays of less than two midnights should be paid on an inpatient basis based on the medical judgment of a physician.

Now that both MedPAC and CMS have reviewed the flawed two-midnight policy and have provided the hospital field with an opportunity to have a constructive dialogue with CMS, it would be premature to take legislative action on any short-stay policy at this point. We do, however, urge Congress to extend the partial enforcement delay of the two-midnight policy beyond Sept. 30, 2015. **In light of the fact that any changes CMS implements through the outpatient PPS rulemaking process will take effect Jan. 1, 2016, we urge Congress to extend the partial enforcement delay of the two-midnight policy until March 30, 2016.** This will not only provide additional time for CMS to issue guidance related to any new policies or admission criteria for hospitals and review contractors, but will allow hospitals time to implement any new policies put forth by the agency.

RECOMMENDATIONS RELATED TO THE MEDICARE RAC PROGRAM

We support MedPAC's recommendation for CMS to base each RAC's contingency fees, in part, on its denial overturn rate. RACs should be held financially accountable for their overzealous audit behavior, and this change could help address the misaligned financial incentives that drive inappropriate RAC denials. It is important, however, that the amount of the performance adjustment be significant in value. It also is important that CMS accurately define and vet with stakeholders the metrics that measure RACs' overturn rates – currently, the agency's methodology is flawed and artificially deflates the overturn rates. For example, it does not account for the fact that appeals of RAC denials are rarely heard in the same year the denial was made.

Further, CMS's forthcoming RAC contracts will likely not account for overturns at all levels of appeal – the agency proposes to include only overturns at the first level of appeal in calculating a RAC's overturn rate. However, these first-level appeals consist of Medicare Administrative Contractor desk audits of the paper record, and are largely considered to be cursory reviews that are biased toward upholding the denial. It is not until the third level of appeal, heard by an administrative law judge (ALJ), that hospitals receive a review of all evidence by an objective party (that is, a reviewer who is not a Medicare contractor). As such, hospitals appealing

inpatient claims to an ALJ have won overturn of the denial 72 percent of the time, according to the Department of Health and Human Services' Office of Inspector General. The final outcome of an appealed claim must be used to calculate fair and accurate overturn rates.

We are concerned that MedPAC's additional RAC-related recommendations, though well-intentioned, would not achieve their stated goal of relieving hospital administrative burden. First, the recommendation that CMS focus reviews of short inpatient stays on hospitals with the highest rates of short stays would neither reduce RAC scrutiny nor administrative burden for hospitals that are not targets of the short-stay audits, nor decrease the overall number of claims audited and denied by RACs. This is because RACs are not limited to auditing short inpatient stays; they may receive approval from CMS to audit any number of Medicare payment rules. Further, CMS allows RACs to audit a certain number of claims per hospital, based on the hospital's Medicare volume (e.g., for large hospitals, RACs can request 600 records every 45 days). The contingency fee structure encourages RACs to demand the maximum number of records every time period. Unless CMS also reduces the audit limits, RACs simply will shift their focus to other audit issues for those hospitals that do not have high rates of short stays.

Similarly, the recommendation that CMS evaluate a formulaic penalty on "excess" short stays to substitute for RAC reviews of short inpatient stays would not curb RAC review for those hospitals unless corresponding reductions are made to RAC audit limits. These hospitals simply would be subjected to the penalty *in addition to* routine RAC audits. We are deeply concerned about the concept of applying penalties based on an arbitrary threshold of what constitutes an "excess" number of short stays. It is unclear how an "excess" number of short stays would be determined. Setting an arbitrary threshold clouds the role of physician judgment, flies in the face of the Medicare program's longstanding policy that medical necessity drives coverage decisions, and ignores legitimate variation in practice. It is imperative to establish any and all policies in a way that recognizes medical necessity and the critical role of physician judgment.

Finally, the recommendation to shorten the RAC lookback period for review of short-stay inpatient claims would create a more level playing field and likely would allow hospitals to rebill more claims. **However, even if the RAC lookback period is shortened to six months for patient status reviews, as CMS has proposed for its next round of RAC contracts, hospitals would not be able to pursue any appeals rights before the one-year filing limit expires.** They would, therefore, have to continue to forgo their appeals rights in order to rebill claims. This is because a hospital could not receive and reply to an audit request from a RAC, receive a RAC denial, prepare an appeal and receive an appeal decision before the one-year filing limit expires. As is illustrated in the attached appeals timetable, it can take six months from the date a RAC denial is received just to get through the first level of appeal. **Alternatively, as noted below, we urge the committee to eliminate CMS's application of the one-year filing limit to rebilled claims.**

Hospitals carefully evaluate claim denials to determine whether to invest time and resources in filing an appeal; they appeal claims because they stand behind the clinical judgment of the physicians who made the decision to admit the Medicare beneficiary. Hospitals that have provided medically necessary services to Medicare beneficiaries should not face the choice of

conceding to outpatient payment – which is often lower – or being penalized for pursuing their appeals rights by potentially receiving no payment at all.
We continue to urge the committee to consider and support the following additional changes to address the systemic problems with the RAC program:

1. **Prohibit any payment structure that encourages RACs to deny claims.** The current contingency fee structure is one-sided in that RACs can deny claims with impunity. Instead, RACs should be paid similarly to other Medicare contractors, such as through a cost-based contract.

2. **Impose a financial penalty on RACs when a denial is overturned on appeal.** A penalty assessed in such instances would curb overzealous RACs and create a level playing field for both RACs and providers in addressing incorrect payments.

3. **Require RACs to consider only the medical documentation available at the time the admission decision was made in determining whether an inpatient stay was medically necessary.** Currently, RACs can review claims three years after the date of service and are able to utilize information that may not have been available to the physician at the time of the admission decision in order to deny claims. This requirement would restrain RACs' current practice of second-guessing physicians' judgment based on the outcome rather than the facts the physician had at the time.

4. **Eliminate application of the one-year filing limit to rebilled Part B claims.** When a Part A claim for a hospital inpatient admission is re-opened and denied by a Medicare review contractor because the inpatient admission was determined to be not reasonable and necessary, the hospital should be able to submit a subsequent Part B claim for services provided within 180 days of a revised or final determination. This would allow hospitals to either rebill immediately after the claim is denied or pursue their appeals rights and receive a final determination on the Part A claim before rebilling under Part B.

5. **Limit RAC auditing of approved issues to a defined time period, instead of approving them indefinitely, as is now the practice.** After the issue's audit time period has expired, RACs should be prohibited from auditing that issue. CMS should then analyze the audit results and offer education to providers in that jurisdiction if warranted. A RAC would need to seek new approval from CMS to audit for that same issue again, but must wait a certain defined time period to allow providers to incorporate education before requesting new approval. Additionally, a senior CMS official should be held accountable for approval of audit issues.

We also urge the commission to review the proposals set forth by CMS in the CY 2016 outpatient PPS proposed rule related to RAC reviews of patient status claims. While we are waiting for further clarification from CMS on how this process will work, we are pleased CMS proposed to make Quality Improvement Organizations (QIOs) the first line of medical review instead of RACs, in order to prevent RACs from making inappropriate denials of patient status determinations.

SITE-NEUTRAL PAYMENT RECOMMENDATIONS

MedPAC has, on numerous occasions, focused on reducing or eliminating differences in payment rates across care settings because it believes this causes distortions in provider incentives. Specifically, the commission has recommended that the differences in payment rates between hospital outpatient departments (HOPDs) and physician offices for 66 selected ambulatory payment classifications (APCs) be reduced or eliminated. In addition, in 2011, MedPAC adopted a site-neutral payment policy recommendation for 10 evaluation and management (E/M) clinic visit services. The commission also has discussed applying a site-neutral payment policy to a set of 12 surgical service APCs, which would reduce HOPD payment to the level paid in an ambulatory surgical center (ASC).

The AHA opposes these site-neutral payment policy recommendations for the following reasons:

- Hospitals already lose money treating Medicare patients in the HOPD (with negative 12.4 percent margins in 2013). We are concerned that further payment reductions would threaten access to critical hospital-based "safety net" services. HOPDs provide services that are not otherwise available in the community to vulnerable patient populations, such as care for low-income patients, for patients with multiple chronic conditions, the disabled and dual-eligible patients.

- Site-neutral payment reductions would endanger hospital's ability to continue to provide 24/7 access to emergency care and stand-by capacity for disaster response. Without adequate, explicit funding for these emergency standby services, the stand-by role is built into the cost structure of full-service hospitals and supported by revenue from direct patient care – a situation that does not exist for physician offices or any other type of provider.

- Payment to hospitals for outpatient care should reflect HOPD costs, not physician or ASC payments. HOPD payment rates are based on hospital cost report and claims data. In contrast, the physician fee schedule, in particular the practice expense component, which is relevant for the site-neutral payment methodology, is based on voluntary responses to physician survey data and has been held flat for years due to the cost of various physician payment "fixes." ASCs do not report their costs.

- The Medicare payment systems for physicians, ASCs and HOPDs are complex and fundamentally different, with many moving parts. Practically speaking, this makes the application of MedPAC's site-neutral policy unstable, with any number of small technical and methodological decisions changing the outcome significantly. Basing hospital payments on such a volatile methodology could have unintended consequences.

GRADUATE MEDICAL EDUCATION

Changing health care needs have policymakers focused on revisiting the financing of graduate medical education (GME) and how physicians are trained. In a 2010 report, MedPAC asserted

that indirect medical education (IME) payments exceed costs and recommended using the "excess" amount for a performance based payment program that would reward hospitals that meet unspecified educational outcomes and standards. The commission also recommended that the Department of Health and Human Services study a range of issues, including the optimal number of residency slots needed by specialty. MedPAC did not recommend an increase in the number of residency positions.

Unfortunately, the commission's proposals overlook the rationale for the current GME payment structure and suggest replacing it with new, untested financing models. **The AHA opposes proposals that would alter the GME financing structure in a way that would reduce direct GME or IME payments to teaching hospitals. Reductions in Medicare financing for medical education would threaten the stability and predictability teaching hospitals need to train physicians for evolving health care system needs and would limit the ability of teaching hospitals to offer state-of-the-art clinical and educational experiences.**

The AHA urges MedPAC and other policymakers to ensure that teaching hospitals continue to have the financial support necessary to continue training talented and diverse physicians. To that end, the AHA strongly supports the Resident Physician Shortage Reduction Act of 2015 (H.R.2124/S. 1148) to add 15,000 residency slots by 2021. The legislation outlines a hierarchy for distributing the new slots, prioritizing teaching hospitals in states with new medical schools, currently have more residents than their Medicare-funded slots, and/or train physicians in community or outpatient settings. At least half of the new slots would be for specialty residency programs with shortages, as determined by the Health Research Services Administration (HRSA). **The AHA urges the committee to end the 18-year freeze on the number of physician training positions that Medicare funds and to support the creation of at least 15,000 new residency positions, as included in this legislation.**

340B DRUG PRICING PROGRAM ISSUES

In May 2015, the commission issued its report to Congress on the 340B Drug Pricing Program. The report was requested by members of the House Energy and Commerce Committee. We are pleased that the commission choose not to insert Medicare policy recommendations into a non-Medicare payment policy area. We also compliment the commission's restraint in not pre-empting HRSA's plans to issue comprehensive interpretive guidance to improve program oversight later this year. Areas that HRSA is expected to address include: the definition of patient eligibility, contract pharmacy arrangements and mechanisms to prevent ineligible patients from receiving the benefit and duplicate discounts for Medicaid patients.

Many AHA members, including critical access and urban safety-net hospitals, participate in the 340B program. For more than 20 years, Congress has provided relief from high prescription drug costs and enabled certain hospitals to stretch scarce federal resources to expand and improve access to comprehensive health care services for more patients, especially low-income and uninsured individuals.

Some stakeholders and interest groups, however, continue to spread misinformation about the program. Here are the facts:

- The 340B program accounts for only 2 percent – or $6.5 billion – of the $325 billion in annual drug purchases made in the United States.

- 340B hospitals provided $28.6 billion in uncompensated care in 2013, which is four times the amount of drugs purchased through the 340B program. Participants reinvest the savings they receive on the discounted drugs in programs that enhance patient services and access to care. They also use these savings to provide free or reduced-priced prescription drugs to vulnerable patient populations.

- In 2013, one out of every three 340B hospitals had a negative operating margin.[1]

- 340B hospitals are subject to oversight by HRSA's Office of Pharmacy Affairs and must meet numerous program integrity requirements. These include yearly recertification, audits from HRSA and drug manufacturers and maintaining auditable inventories of all 340B and non-340B prescription drugs. In recent years, HRSA implemented additional program integrity efforts, and the AHA has encouraged HRSA to develop a process to help financially distressed providers meet the new program integrity provisions.

The AHA strongly supports the 340B program's current intent and purpose. It has a proven track record of enabling eligible entities, including certain hospitals, to stretch scarce federal resources to expand and improve access to comprehensive health care services for low-income and uninsured patients. It creates savings on outpatient drug expenditures to reinvest in patient care and health activities to benefit communities and save government funds. Given the increasingly high cost of pharmaceuticals, the 340B program provides critical support to help hospitals' efforts to serve the most disadvantaged in our society and build healthy communities.

RURAL PAYMENT ADJUSTMENTS

In its June 2012 report, the commission examined rural Medicare beneficiaries' access to care, rural providers' quality of care, special rural Medicare payments, and the adequacy of Medicare payments to rural providers. Much of the commission's discussion focused on its assertion that not all rural hospitals are isolated. Specifically, the commission notes that 16 percent of critical access hospitals (CAHs) are located less than 15 miles from another hospital. However, there was no discussion of the full story of how these hospitals became CAHs, which is important contextual information.

Currently, to become a CAH, a hospital must be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads. However, prior to Jan. 1, 2006, this requirement was waived if a hospital was state-certified as a "necessary provider" of health care services to residents in the area. This

[1] American Hospital Association Annual Survey, data for 2013.

provision provided governors, who are much more knowledgeable about and in touch with the health care delivery systems in their states, the flexibility to waive the "one-size-fits-all" mileage requirement if they recognized that certain hospitals were absolutely essential to their communities.

We are concerned that MedPAC is using a one-size-fits-all consideration of these hospitals – viewing them only through the lens of proximity to the nearest hospital without any additional considerations. **In reality, there are many unique circumstances that must be taken into account when analyzing CAH location, including distance to the next nearest hospital, availability of post-acute care services, size of the hospitals, size and location of the surrounding population centers, weather, geography and posted speed limits.** Each rural community is unique and should be considered as such when discussing payment policy.

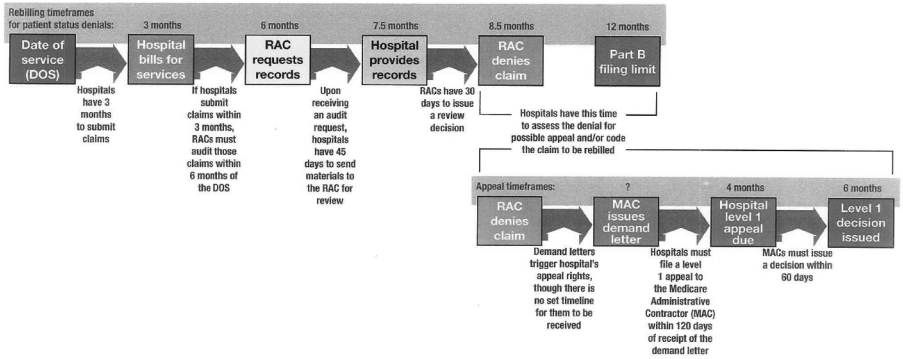
The commission also discussed the current low-volume adjustment and asserted that it is duplicative with the sole-community hospital (SCH) adjustment. **We strongly disagree with this conclusion.** The low-volume adjustment is obviously intended to account for the higher costs associated with treating a lower volume of patients – such providers frequently cannot achieve the economies of scale of their larger counterparts. The SCH adjustment, however, helps preserve access to care by targeting hospitals with higher-than-average costs given their circumstances. As MedPAC itself found in its June 2001 report, SCHs' higher costs persisted after adjusting for certain factors, such as low volume, case mix and teaching activity. The commission stated that the higher costs could be due to other factors than scale, such as longer lengths of stay linked to an inability to place patients into appropriate post-acute care. Thus, the two adjustments address two different challenges faced by small, isolated hospitals.

CONCLUSION

The AHA and the hospital field appreciate your consideration of these issues. The AHA is committed to ensuring that the Medicare program continues to help the patients who depend on it. We look forward to working with the committee as it considers the important Medicare payment policy issues raised in the MedPAC report and at this hearing.

Hospital Timeframes to Rebill vs. Appealing Patient Status Denials

This timeline presumes implementation of the CMS RAC program changes announced in December 2014, as well as adherence by hospitals and contractors to statutory and contractual timeframes.



Chairman BRADY. Thank you, Dr. McDermott.

Mr. Johnson, you are recognized.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Miller, let me start by thanking you for testifying today. As you know, our nation has an incredibly complex hospital payment system, with different coding classification systems and reimbursement systems, and where the procedure is performed.

MedPAC concluded in its June Report that, because Medicare generally pays more for patients who receive similar services in inpatient settings compared with outpatient settings, hospitals have a financial incentive to admit patients. To address the problem, MedPAC drafted a crosswalk to link 10 comparable inpatient and outpatient surgical codes. Such a crosswalk allowed MedPAC to compare these similar codes, which you then found resulted in inpatient surgical costs, roughly 4,000-plus higher than for similar outpatient surgeries.

I think it is an important step to ensure greater transparency in Medicare spending, so we can ensure hospitals are not admitting patients solely for financial profit, but because it is medically necessary. So I would like to take these moments to ask a couple specifics.

First, how important is it to have a crosswalk between similar surgical codes for inpatient and outpatient payment systems?

Mr. MILLER. I think, if the committee wants to pursue the idea that it seems to be asking questions about, site-neutral, that type of thing, you have to have something like that.

Mr. JOHNSON. Okay. How difficult was it for MedPAC to establish a crosswalk for these 10 surgical codes?

Mr. MILLER. It was not simple. And I will just say, again, I think reasonable people could come to different places in crosswalking individual codes from one location to the other. But I think there is probably a manageable process that people could go through to come to a crosswalk that would generally be viewed as acceptable.

You would want a clinical, as I said, overlay after you did those crosswalks, to make sure you were doing things in a clinically rationale way. I would say that.

Mr. JOHNSON. Well, thanks. And finally, in your opinion, is this something CMS could pursue in the future?

Mr. MILLER. I do. I think—I am sure they would prefer to speak for themselves, but, you know, my sense is that they could engage through a contracting process with, you know, firms that exist that do this, bring something in that would be used for public use. They would have to work with it, both mechanically and clinically, as I said, because I don't think these things are just off-the-shelf, everything is perfect, you know. They would have—and they would want to put it out for notice and comment, get people—the hospitals, physicians, beneficiaries, everybody—to comment on it. But I do think it is a process that they could pursue.

Mr. JOHNSON. Everything is off the shelf, just like this hearing.

Mr. MILLER. Yes, right.

Mr. JOHNSON. Thank you, sir. I appreciate your opinion, and I appreciate your help on that issue. Thank you.

Mr. PRICE [presiding]. The gentleman yields back. Mr. Kind from Wisconsin is recognized for five minutes.

Mr. KIND. Thank you, Mr. Chairman.

Dr. Miller, thank you for being here. I usually ask you a quick question about rural hospital reimbursements. In your 2013—your recent report, you indicated in 2013 the overall margin rate for rural hospitals was about 22 percent. But also in the report you acknowledged that a large part of that margin was based on the HIT incentive programs that have been going to rural hospitals. That now is being phased out.

So, are you—is MedPAC taking into consideration the phase-out of the HIT incentive program, and what that is going to do to margins for rurals? Because 40 percent of them are operating in negative margin territory, already.

Mr. MILLER. I think the answer to that is yes. The Commission—and one thing, and it went by really fast in my opening statement, so I will just say it again. We have made, for the last few years, positive Medicare payment increases for hospitals. We recognize that rural hospitals are about at 0.2, but let's just call it zero. Overall margins are negative for hospitals in Medicare. And, consequently, the Commission has—among other reasons, the Commission has made recommendations for payment updates for rural and urban hospitals. So——

Mr. KIND. Okay.

Mr. MILLER. And, in thinking through those issues, we take into account things like your—exactly what you are asking. What is going to happen to this? What is going to happen to that. And we look forward to all of that——

Mr. KIND. Okay, very good. Let me shift gears. Obviously, CMS has been pushing the metal a little bit hard now on changing the payment system, going to a more value and outcome-based payment model. You, undoubtedly—and MedPAC, undoubtedly—has been watching this very closely. I want to get your impressions on how that is going, and whether there are some additional areas of acceleration when it comes to value-based payment models, especially in the post-acute care area, where I think there is some substantial savings that can be had, while also increasing the quality of care.

Mr. MILLER. So we are not talking about hospitals or rural, necessarily——

Mr. KIND. Now, we have——

Mr. MILLER. We are talking bigger——

Mr. KIND [continuing]. Moved on to a totally different payment question here.

Mr. MILLER. Okay. I am going to start. But if I don't have the right question here, you know, just redirect.

So, if you are talking about kind of large, you know, payment delivery reform types of things, like accountable care organizations——

Mr. KIND. Right.

Mr. MILLER [continuing]. And that type of thing, so what I would say is, you know, coming out of the health reform legislation—so there were things like the re-admissions penalty, which I know is not particularly popular, but has actually had the effect of

reducing re-admissions. And just by the way, the Commission has some ideas to address hospitals that deal with disproportionate shares of the poor that we could talk about if anybody wants.

Moving on from that, ACOs, I think the analysis we have done there suggests that ACOs are producing small savings, onesie and twosie percent types, and it is in parts of the country where fee-for-service tends to be high, which, if you think about it for 30 seconds, kind of makes sense.

On the bundling and post-acute care, there hasn't—you know, there is that demonstration—I don't want to make a global statement, and I don't think this is a Commission statement, but there hasn't been a lot to show there yet, that I have seen. And I think there is some concern on the part of the Commission that, you know, lots of people wanted the data, a lot fewer people wanted to take risk. And to the extent they wanted to take risk, they wanted to do it for only a few services.

And so, getting a lot of traction in the post-acute care, say through a bundling strategy, I don't see a lot of it yet, and I am worried that what is out there isn't going to necessarily——

Mr. KIND. Well, Mr. Brady and I have been working on some proposals, and undoubtedly would like to follow up with you and others at MedPAC for some advice or guidance, as we get ready to move forward on that.

Mr. MILLER. Okay.

Mr. KIND. Great, thank you.

Mr. PRICE. The gentleman yields back. I was next in line, so—maybe I will let the Chair take over here, and then I will assume my rightful position.

[Laughter.]

Chairman BRADY [presiding]. So Dr. Price declined to recognize Dr. Price?

[Laughter.]

Chairman BRADY. Is that the case? Thank you for letting me step out for a minute.

Dr. Price, you are recognized.

Mr. PRICE. It was this perspective that I—welcome back.

Mr. MILLER. It is good to see you.

Mr. PRICE. Thanks for coming. And I appreciate your qualification on—as a surgeon—on your definition or your description of the difference between a medical observation and a surgical observation, and we will have a conversation about that offline.

Mr. MILLER. Okay.

Mr. PRICE. The—I have a number of questions I want to raise. The first is on meaningful use and electronic health records. In a 2012 MedPAC report you commented—MedPAC commented on—talking about the decreased uptake of utilization by physicians of EHRs. And I have been surprised that in the last three reports, or last three years, MedPAC hasn't addressed the issue of meaningful use and EHRs. Is there a reason for that? Do you plan on addressing this issue that is so incredibly important for the——

Mr. MILLER. We can certainly dive back into it. You know, we are a small operation. We kind of—we can't cover the waterfront every year, all day. And so we tend to focus on things and then

move to other issues. But if there is an interest in it, we can certainly try and look back into it.

Mr. PRICE. Let me just share with you. I spent a couple hours this past Monday night in Atlanta with a group of, oh, 80 to 100 physicians on the specific issue of meaningful use, and the incredible challenges that they are having in their practice, caring for their patients: decreasing productivity, increasing costs, decreasing access to care from the patient standpoint. And so I would urge MedPAC to take another look at it, especially in view of the fact that it appears that CMS is forging forward with stage three without regard to any information or statistics, real metrics that demonstrate that stage two has actually been a success.

Let me shift to site-neutral payments. And I appreciate MedPAC's perspective on this, and the push that you all have made. I think it is an incredibly important issue. And I am curious as to whether or not you believe that CMS could go ahead and do site-neutral payments right now, without Congress acting.

Mr. MILLER. Without Congress acting? I don't know the answer to your question, off the top of my head, not in any real, significant way, at least that we have been thinking about it. The recommendations we have made, and I think some of the discussion here—although I would really have to think about it—would require more changes in law. But I am not 100 percent——

Mr. PRICE. Sure.

Mr. MILLER. It would depend on what you meant by "site neutral," I suppose.

Mr. PRICE. Well, especially outpatient surgical procedures and what I think are significantly-increased costs to the system, yes, but also, as Dr. McDermott has pointed out, to the patient, as well, in terms of copays and deductibles on things as insignificant as minor procedures, but as significant as major procedures like joint replacements, which are now being done in an outpatient setting in many, many instances, so I would——

Mr. MILLER. And I want to say I want to think about the answer to your question, because, depending on if it is done inside an existing system, I wonder what flexibility the Secretary would have. So I want to withdraw a little bit, and——

Mr. PRICE. Great.

Mr. MILLER [continuing]. Think about it.

Mr. PRICE. I would love to——

Mr. MILLER. Yes, I don't know the answer to your question.

Mr. PRICE. In-office ancillary services exception, GAO reported in multiple studies for between 2004 and 2010 that they didn't uncover any evidence at all that suggested that it would be appropriate to repeal the in-office ancillary exception. Milliman did a study that showed that costs in the hospital were greater than costs in the office. JAMA has done a recent report that demonstrated the same.

Can you opine as to—or can you share with us what information you have provided to CMS as it relates to this, or opine as to whether—why you believe HHS or the Administration seems to be incentivizing a move towards hospitalization, as opposed to—and utilizing services in hospitals, as opposed to the office for these kinds of procedures and examinations?

Mr. MILLER. Yes, and I am just going to—and you tell me if I am off base. I am not—I don't feel so much that people are actively trying to incent the move from office to hospital, although you may be aware of something I am not.

More—the way I think about the issue is, historically, private and Medicare created payment systems to pay for hospital care and physician care. Hospitals is no mystery. Hospitals are more expensive.

Mr. PRICE. Yes.

Mr. MILLER. And a big argument is why and what people should pay for, and all of that. And so you end up with payment systems for comparable services that look like this. And then, hospitals have started to purchase physician practices, and then just shift the billings from one setting to the other.

More what I see is that motivation, is that there is a financial signal out there, and people have begun to pick up on it, and are moving in that direction. And our recommendations on site-neutral—and I think what was included in the President's budget, although I don't have that wired in my head—were to try and do a bit more of leveling that out——

Mr. PRICE. Correct.

Mr. MILLER [continuing]. So that that incentive didn't exist as strongly.

Mr. PRICE. Correct. Did that mean my time is up, or that I have got a minute?

Chairman BRADY. Thank you both very much.

Mr. PRICE. I look forward to getting back with you, Dr. Miller.

Mr. MILLER. Yes. Sorry for going on.

Chairman BRADY. Mr. Pascrell, you are recognized.

Mr. PASCRELL. Thank you, Mr. Chairman, and thank you, Dr. Miller, for your service.

I would like to discuss with you graduate medical education. In my home state of New Jersey, there is 42 hospitals maintaining residency programs. That number is increasing. I am proud that our hospitals are at the forefront of training the next generation of physicians. I know you are very interested in that.

Mr. MILLER. The Commission is, yes.

Mr. PASCRELL. Despite the fact that our teaching hospitals turn out many highly-trained physicians every year, New Jersey faces a physician shortage. My state's challenge retaining physicians in New Jersey after they complete their residencies is a big problem. But many of the states that my colleagues here today actually benefit from this problem. States like Pennsylvania and Delaware, with lower costs of living, benefit from residency programs that New Jersey hospitals undertake. When physicians complete their residencies, they move out of the state.

A few months back I met with a family physician who completed his residency in New Jersey, and then moved to Texas to practice where the cost of living is much lower. Given the shortage in the physician workforce pipeline, impending physician retirements, the aging of the Baby Boomer population and a number of other issues, we need to be growing the number of Medicare-supported residency positions, not reducing them.

The landscape of how we deliver health care is changing. The Affordable Care Act laid the foundation for moving away from a fee-for-service model towards quality-based payment systems. Congress could take one step further by repealing the sustainable growth rate earlier this year. That is what we did.

One of the issues MedPAC has highlighted in the past is the role that GME funds and teaching hospitals can play in preparing new physicians to practice in a quality-based health system. One fact—one of our hospitals in New Jersey, the Hackensack Medical Center, has an extremely successful accountable care organization. They have adopted their GME program to promote this integrated tier model.

Dr. Miller, can you talk a little bit about how teaching hospitals can leverage their position training the next generation of physicians to underscore the importance of quality-driven health care, care coordination, and a team-based approach to health care, which we talk about all the time? But this is going on in places throughout the United States. Would you respond to that?

Mr. MILLER. I think so. So the Commission did some work back several years now, and, as I mentioned quickly in my opening statement, I think the IOM—read more recently—said some very similar things. And what the Commission said is we took a look at curriculums. And we are concerned that in the residency trainings there was not focus on team-based care, using evidence-based metrics to guide care, you know, using the HR—you know, the stuff that you think about in a reformed delivery system.

And what we said was there should be a set of criteria—and, given time, I won't drive you through it—there should be a process that includes many stakeholders—which I won't drive you through, it is all written down in the report—to come to this more comprehensive look at graduate training, to drive towards delivery reform, to have physicians and other health professionals who are versed in these skill sets, as well as training in alternative settings.

Physicians see a lot of patients in nursing homes, offices, clinics, you know, urban and rural. And to drive in that direction, and then attach the GME dollar to the programs that meet that criteria. They could be hospitals. And, to the extent that your—the hospital example you said is driving in that direction, at least in the Commission's point of view, that is what we would be looking for.

Mr. PASCRELL. Well, let me ask this final question, Dr. Miller. If you say—and I believe you believe in what you said—wouldn't it be—an incremental increase in those residency positions help states like New Jersey?

Mr. MILLER. Well, we were so close, but the Commission does not agree with that, and——

Mr. PASCRELL. Why not?

Mr. MILLER. I will tell you. The Commission's view was simply expanding the number of slots is going to produce more of what we have, and it is not necessarily going to keep residents in your states. They can still leave.

Mr. PASCRELL. Right.

Mr. MILLER. And so I think there was some concern that, without a much more rigorous look at, you know, changing the grad-

uate medical education strategy, and what is needed, we shouldn't just simply increase the number of slots.

Mr. PASCRELL. Well, Mr. Chairman, I have a great deal of respect for Dr. Miller, as you know.

Mr. MILLER. But you disagree.

Mr. PASCRELL. But, through the Chair, I would like to get a more definitive answer to the question. We don't have the time right now. With your help, I think we can.

Chairman BRADY. I would be glad to.

Mr. PASCRELL. Thanks.

Chairman BRADY. And, just so you know, we are going to be holding a hearing dealing with GME, and sort of get deeper into this subject, because it is a bipartisan——

Mr. PASCRELL. In the fall?

Chairman BRADY [continuing]. Issue, going forward. Yes.

Mr. PASCRELL. Okay, thank you.

Mr. MILLER. And I want you to know that if you would like us to come to your office and—you or your staff—and just take you through all of it, we are——

Mr. PASCRELL. Yes, I think that would be a good idea, too.

Mr. MILLER. More than happy to do that.

Mr. PASCRELL. Thank you, appreciate it.

Chairman BRADY. Mr. Smith—Dr. Smith, you are recognized for five minutes.

Mr. SMITH OF NEBRASKA. I thought physicians were leaving rural America for urban America, but I hear otherwise. So obviously, I represent a rural constituency, and there are many challenges. And I talk to providers, and especially in rural areas, where, you know, support staff is probably not what it is in urban areas. I am not complaining about that, but the recovery audit contractor issue has had a significant impact, and it just has frustrated a lot of providers. So I had a bill last Congress which would have reformed the RACs, and I am continuing to work on this issue.

But I was wondering. Now, the Commission made several recommendations for the RAC program. Can you touch on those recommendations, perhaps, and maybe give a brief rationale for each one? I don't want to put you on the spot, but if you do have those handy——

Mr. MILLER. No, I do have them handy. This was in our most recent report. I figured it would come up at some point.

So, with respect—just focusing on the RACs—and we also made recommendations on beneficiary protections, but just on the RACs, we basically said three things, that, instead of the RAC review being very comprehensive and hitting all kinds of hospitals, focus the RAC efforts on hospitals that have apparent patterns of one-day stays. And so, in a sense, it is just—it is targeting.

Number two, RACs are a contingency fee-type of operation, and we want the RACs to bring the most credible and defensible cases, not just sort of, you know, take as—take their chances, and do as much as possible, and then see what happens. And so, we would say the contingency fee should, in part, be adjusted if they have poor overturn rates. They bring lots of cases, they get overturned,

then their contingency fee should be brought down. Make it a financial incentive to bring good, strong cases.

The third thing was to adjust the look-back period for the RAC. So RACs were able to go back several years on hospitals and say, "I am challenging this particular admission." And, you know, two or three years, a lot of administrative costs trying to dig that out, electronic record. And it may be past the point that, if the claim was denied, that the hospital couldn't bill for the—a set of outpatient services that they did provide.

So you might say, "Well, this inpatient was unnecessary, but they did provide some outpatient services coming in the door," if you will. And so we said, "That should be better aligned, so that the hospital has the ability to make this calculus: 'I can defend this case, and so I am going to appeal,' or, 'Actually, I am not so sure I can defend it, so I am not going to appeal it, I am going to actually just take the lower outpatient reimbursement, and walk away,'" and that is the dynamic, rather than appealing everything or appealing nothing, that we are trying to get set up in there.

Mr. SMITH OF NEBRASKA. Okay.

Mr. MILLER. So those were the three RAC things.

Mr. SMITH OF NEBRASKA. Sure. I appreciate that. Shifting gears here just a bit, I represent a number of critical access hospitals. Some are—well, they are all rural. Some of those are actually remote. And I know that you have previously said that the closing of rural hospitals is proportionate to the closure of urban hospitals. Is that an accurate description?

I would say that the impact to the community, or—and perhaps to the patients themselves is disproportionate. Does the Commission take that into consideration at all?

Mr. MILLER. Yes. And by saying it is proportionate, I don't think anybody was trying to say—and this drives right to a point that I would like to make; you may agree or not, but it does—the Commission, in writing that down on paper and reporting what is happening, we aren't trying to say, "and therefore, there is no issue here." I—you know, obviously, if you are in a urban area and a hospital closes, and there is two other hospitals right nearby, the significance of that closure is very different than if you are the only hospital within 50 miles.

And the thing that we are trying to say is rural—and this comes from our rural commissioners. First of all, think of rural this way. There is rural, as in 50 miles from any other provider on a hilltop, and there is rural adjacent to an MSA. You are right across the border from, you know, a metropolitan statistical area.

The access implications of closure in those two settings are very different.

Mr. SMITH OF NEBRASKA. Right.

Mr. MILLER. You know? You might have to travel somewhat further into the MSA, but you are—still have access to something.

And so, the point that I think the Commission has been driving at for several years is think about the supports that go out to rural areas. And what you want is to really support that isolated, low-volume provider, because they can't ever be expected to cover their costs. They are too small, there is not enough admissions that roll

through, or outpatient visits to cover their costs, and there is no other alternative.

But all over the place we are—I think I am done.

[Laughter.]

Chairman BRADY. You know, by the way, no other witness ever stops when I do that, so I appreciate that very much.

[Laughter.]

Mr. MILLER. But I am going to finish. It is very short. A lot of our current supports for rural areas kind of make it critical to the community to hang on to their hospital, even if that hospital is close to another hospital, and they both have low volume, and, bluntly, they are more likely to have low quality. Whereas, if there was a consolidation, they might be economically more viable, and might even improve quality there. Sorry about that.

Chairman BRADY. Thank you, Doctor, and thank you, Mr. Smith.

Mr. Davis, you are recognized.

Mr. DAVIS. Thank you. Thank you very much, Mr. Chairman.

Thank you, Mr. Miller. Illinois's 7th congressional district, which I represent, contains the most hospital beds of any congressional district in the nation. In addition to that, we are home to four major academic medical centers. According to the new workforce projections, the nation faces a shortage of between 46,000 and 90,000 physicians by 2025, with shortages most acute in surgical specialties, the result of a growing aging population, and the newly insured, which tend to need more specialized care, especially the elderly, who are living longer. Medical schools have increased enrollment, and teaching hospitals are expanding training to address physician shortage. Medical schools and teaching hospitals are also working hard to ensure that new doctors coming into the system are trained to serve in new delivery models that focus on care coordination and quality improvement.

I am concerned that reductions to Medicare graduate medical education would harm teaching hospitals' ability to effectively train the number of physicians we need in the future, and would adversely impact access to care for both the elderly and the newly insured.

My question is, while Congress seeks to reform Medicare payments to graduate medical education, shouldn't we also be making sure—or trying to make sure—that we are able to meet the projected need, as we continue towards 2025?

Mr. MILLER. I think the answer to that is yes. I think a couple things that I would say. With absolute respect—and I don't know the source of your numbers—but I would say, depending on who is doing the projecting, you can get very different kinds of numbers of what shortage and what is in shortage.

There are also people in the academic community who have less of a stake in this, and have looked at this, and have argued that it is not so much aggregate supply as distribution problems, and have suggested also changes about which, you know, level of physician versus a nurse practitioner versus a PA that could—for example, to, you know, fill some of the needs.

What I would say directly to your points are one question is, given the dollars that go to support slots, the Commission could

think about which of those specialties are likely to either be in short supply or—and/or are less lucrative for the hospital to support, and shift the given dollar to support those kinds of training programs. So, some interns and residents are very valuable to the hospital, and they will support them even without a subsidy. Others are less valuable to the hospital, and they are less likely to support them. So you could think of, given a dollar, how you distribute that dollar.

A second thing I want to say is the Commission did not ultimately reduce indirect medical education. It did redirect how it was—you know, it went to the various programs, and that is what I was saying in response to the question before you.

Mr. DAVIS. Let me ask you a little bit about site-neutral payment policies. Do you see this adversely affecting teaching hospitals and disproportionate share hospitals, perhaps more than others, because of the clientele——

Mr. MILLER. I definitely——

Mr. DAVIS [continuing]. That they——

Mr. MILLER. I definitely see where you are going, and the Commission contemplated this. And so I am just going to blow past this part. It depends on what kind of site-neutral you are talking about; it will affect different hospitals differently.

But let's just say, for the purposes of your question, some site-neutral policy has an effect on a hospital that serves a disproportionate number of poor folks. The Commission said you could mitigate that, the effect of the policy, by looking at the amount of, you know, poor people, say, that hospital serves. They actually directly contemplated policy designs that would try and address that problem.

Mr. DAVIS. Thank you very much. I know that time is a factor, but I would like to discuss these issues with you further, if we have an opportunity to do so.

Mr. MILLER. As always, we are happy to brief you and your—or your staff, whichever way you would like to go.

Mr. DAVIS. Thank you very much.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Marchant, you are recognized.

Mr. MARCHANT. Thank you, Mr. Chairman. I would love to pick up where Chairman Brady was talking at the very beginning. The Affordable Care Act splits the DHS funds into two pots: 75 percent of the dollars go into a pot that is being reduced every year; and the other 25 percent, which is sometimes referred to as the empirically justified pot, is not being reduced.

It is my understanding that MedPAC came up with this notion of empirically justified. Can you explain how MedPAC got to that classification, and their reasoning behind it?

Mr. MILLER. I can, and I just—I think you are clear in your mind, I just want to be clear in everyone else's mind. We didn't come up with this system that you are referring to, the two parts, but we did come up with the empirically justified notion.

So, this is work—and this is way back, now, but this is work when we were thinking about the indirect medical education add-on payment, and the disproportionate share add-on payment. And

here is a way to understand it. It is a little bit technical, but I can do it, I think, very simply.

Here is a hospital's cost per case. And, thinking about what drives that cost per case, it might be more complex patients in one hospital or another, or differences in wages from one area to another, or something like that. And so you could see that cost go up and down, based on what is happening in a given hospital.

There are add-ons for IME and, to your question, disproportionate share. And the rationale for it has changed over time and who you are talking to. But at any—one way to think about it was it was supposed to help hospitals that served disproportionate shares of the poor. And the thought was serving poor folks increased the cost for the hospital.

And so, if you run that analysis—which I can take you through in detail, but for this conversation, if you run that analysis—it says that is true, but it is this much more, and the adjustment is this much more. So, the adjustment over-achieved, if you will, and gave the hospitals more than their cost increase.

We just went through the analysis and said the adjustment actually, you know, should be smaller than it is. And we actually didn't even make a recommendation, we just analytically went through it and said this adjustor is set too high.

Mr. MARCHANT. Is it your opinion that the DHS money is going to the hospitals with the greatest need?

Mr. MILLER. All right. I know you think this is a yes or no question.

[Laughter.]

Mr. MILLER. But let me tell you—let me say it this way. If you think it is about poor Medicare patients, the answer is no, because the DSH adjustor contemplates poor Medicare patients and Medicaid. If you think it is about supporting poor Medicare and hospitals that get lots of Medicaid patients, it is probably tracking that. If you think it is about uncompensated care, it is not tracking that, so it depends on what you——

Mr. MARCHANT. The next question——

Mr. MILLER [continuing]. What you think—sorry.

Mr. MARCHANT. The next question may help you with that.

Mr. MILLER. All right.

Mr. MARCHANT. I am particularly interested in the hospitals in the State of Texas. As you may be aware, we are not a Medicaid expansion state. So it is my understanding that The DHS formula is based, in part, on Medicaid days for hospital.

Mr. MILLER. It is.

Mr. MARCHANT. Is it possible that the—that in addition to losing money on the Medicaid DHS side, Texas hospitals are also losing money on the Medicare DHS side because of how the formula is calculated?

Mr. MILLER. It is correct that if you have more Medicaid patients moving through your hospital, your DSH will be higher.

Mr. MARCHANT. So, in a state that didn't expand, it is arguable that your volume is not what it would be in a neighboring state that has a similar situation that had expanded?

Mr. MILLER. I think, factually, that is a true statement.

Mr. MARCHANT. So I have one, two, three, four—six hospitals that have contacted me that I believe they feel like that their funding has been affected by the fact that Texas is not an expansion state, based on the formula.

Mr. MILLER. I don't think the fact set is wrong. Without making a judgement about what people want to do, I think the fact set is correct. If you have more Medicaid patients moving through your hospital, your DSH payments will be higher.

Mr. MARCHANT. So we are preparing some legislation that we will present to the committee to try to rectify this. Thank you.

Chairman BRADY. Thank you. Mr. Roskam, you are recognized for five minutes.

Mr. ROSKAM. Thank you, Mr. Chairman.

Dr. Miller, thanks for your time. My question has to do with some of the work that The Oversight Subcommittee has done at Ways and Means, particularly in the—looking at fraud and improper payments.

So, a few months ago we had the individual who is in charge of anti-fraud efforts at CMS before the subcommittee, and we posed a simple question to them. And the question was, "What is your fraud and improper payments rate?" And they said it was 12.7 percent, which is a number that is so big it just takes your breath away.

Now, just for the sake of creating a sense of wonder, we had the person who is in charge of anti-fraud efforts at Visa, the credit card people, asked them the same question. His answer was, on $10 trillion worth of global transactions, their fraud rate is .06 percent. So this cavernous difference just really does take your breath away.

There is a lot of discussion about how it is that we are going to make sure that the trust fund isn't depleted and so forth. One of the things—there is a general discussion about improper payments as one of the goals that you have, mitigating against improper payments.

So, the reason for my inquiry about improper payments is this. Congress basically—you know, if you look out over these different things that we have done over the past few months, we have got a highway trust fund that is going broke, we have got this, that, and the other thing, we have the SGR, you know, Congress is basically grubbing around in the forest, looking for truffles, and trying to come up with a bushel of money to pay for these things.

And yet, the amount of money that is going out the door in improper payments just literally, at our hearing, it just took our breath away. You do a back-of-the-napkin calculation on this, and it is—you know, it is a billion dollars a week. And the cumulative nature of this is just incredible.

What insight would you have for us on the improper payment side, in particular? Because the interesting thing is there is obviously nobody that is defending the status quo. It is not a partisan issue, it is not a philosophical issue, it is not a geographic issue. It is just a common-sense thing, where we should all agree that payments should be proper. And, if they are proper, we are going to save a fortune.

What insight would you have for the committee, as we venture out into this, particularly in the improper payment arena?

Mr. MILLER. Right. And I just want to preface I am probably not the—you know, the fraud guy that you want to answer this question. The Commission tends to think of payment policy, looks at distortions, tries to stop, you know, bad practices. But detecting fraud is kind of a different option.

So, the first thing I would say about the size of the number—and in no way am I trying to defend anybody or anything—is, you know, when I have gotten close to this issue a couple times in my life—and not close enough, and not really versed in it—there is this difference between fraud and catching fraud, and documentation of a service. So a service was provided, it is a legitimate provider, but someone takes it apart and says, "You didn't provide the right piece of information." And I don't know if that 12 percent versus whatever you said——

Mr. ROSKAM. I take your point. And just parenthetically, here is part of the problem with CMS. They can't tell you the difference.

Mr. MILLER. And that is why, every time I get close to this, my head pretty much explodes. And so I am probably not the right person to do this.

But the thing that I would say—so there are—you know, there is this distinction between outright fraud—and fraud is complicated, because people are actively trying to avoid detection, and I think that makes it hard. There is a cost of detecting it, and a cost of payment ratio. Those are generally pretty positive. And I have seen numbers like that.

The other thing, which is just an off-comment I will say out loud, I think some of these data releases, where you begin to just kind of look at, you know—look at what the raw data says, has driven CMS and some of the other program integrity folks in directions that they probably wouldn't have otherwise seen, you know, individual sets of providers who come out at the top of the heap, and are just pulling reimbursements that are just unbelievable. I think those kinds of things, those public releases of data, can also help, almost from a crowd sourcing point of view, to get other eyes on the problem.

Mr. ROSKAM. So a sunshine policy. I mean that is sort of——

Mr. MILLER. Yeah——

Mr. ROSKAM [continuing]. Disinfectant theory.

Mr. MILLER. My sense is that those things have driven people into identifying providers that had huge drug spends, you know, huge Part B spends, that type of thing.

Mr. ROSKAM. Okay.

Mr. MILLER. But I don't know this issue real deep. I understand what you are trying to ask, but——

Mr. ROSKAM. Okay, thank you. Yield back.

Chairman BRADY. Thank you.

Mrs. Black, you are recognized.

Mrs. BLACK. Thank you, Mr. Chairman. And thank you for being here, Dr. Miller. A very interesting discussion today.

I want to ask you about the Medicare hospital area wage index, which is supposed to ensure that Medicare hospital payments reflect the geographic differences in wages. I have concerns that many have raised over the years that the area wage index is neither accurate nor fair. The fact is that around one-third of all hos-

pitals who receive exceptions to the area wage index shows that the system is not working.

I am even more concerned about the adverse impact that the current system is having on hospitals in Tennessee, in particular, and in the South, across the South, which have seen their area wage index levels rapidly decreasing over the years, while the area wage index levels in other states have been increasing.

So, Tennessee hospitals are being penalized, because they have experienced an increase in cost, including wages over the years, but these increases have not been quite as high as the hospitals in other states, where—with the wage index levels. It is simply unfair. I mean they have done a good job in keeping costs down, but they are being actually punished for that.

So, back in 2007 MedPAC actually recommended that Congress repeal the area wage index. And is this still MedPAC's recommendation, that Congress would repeal this wage index?

Mr. MILLER. I got to tell you, I have been tearing up through this whole thing, because people have kind of forgotten that idea. And the Commission did make a set of recommendations. We do understand what you are saying, and the issues that are being raised there. And we made that recommendation several years ago, and the fundamental—there is a number of things that are going on in it.

But to get to the heart of your question, what is going on is we would move the wage index system off of a hospital-reported wage, and base it more on area wages in—or wages in the area for the labor that hospitals, offices, post-acute-care providers are drawing. And that may sound like a big, technical thing, but what it actually does is, if a hospital decides that it happens to be flush, and it raises its wages, all other things being equal, the wage index relative to other hospitals goes down, because it is down across hospitals. Whereas, we think it would be a lot fairer to hospitals and other providers to base it on the wages in the area, which are much more—less sensitive to an individual hospital's behaviors. And we think that that would bring some greater equity and address some of the issues that you are raising.

There is a whole set of other things which I won't make you crazy with that we also recommended at the same time. But, yes, that is our policy. We did recommend that change. We think it addresses at least some of the things that you are raising.

Mrs. BLACK. I know that that was your recommendation back in 2007. Is MedPAC doing anything now to update that recommendation?

Mr. MILLER. We can go through and update the analysis again. But the principles still stand. And, I mean, bluntly, this requires the Congress to take action.

Mrs. BLACK. Okay.

Mr. MILLER. And you know the dynamics here. I mean this means some——

Mrs. BLACK. That is right.

Mr. MILLER. Right. And that is the issue.

Mrs. BLACK. There will always be winners and losers. But when we look at what is happening in Tennessee, it really is an unfair system.

Mr. MILLER. And——

Mrs. BLACK. For our reimbursements. Thank you, Mr. Chairman, I yield back.

Chairman BRADY. Thank you.

Ms. Jenkins, you are recognized.

Ms. JENKINS. Thank you, Mr. Chairman, for holding the hearing.

Thank you, Mr. Miller, for joining us. I want to return to a discussion Congressman Smith started with you, and discussed the issue of rural hospitals, and some closures.

MedPAC's March 2015 report addresses the rural hospital closure crisis, and finds that rural hospitals represented 44 percent of all closures. The report finds that the closed hospitals are an average of 21 miles to the next nearest hospital. Yet the report does not specifically address the issue of access to care in rural America.

My congressional district has a number of these rural hospitals, and the State of Kansas has 83 critical access hospitals, more than any other. These hospitals provide excellent care to my constituents. And, without them, my constituents would lose local access to care. When a patient has a heart attack, 21 additional miles of travel makes a difference.

So, my question is, has MedPAC considered the impact of access to care for rural Americans if and when these necessary safety net providers close?

Mr. MILLER. So, I mean, my answer would be yes. Each year we assess access, quality, capital markets, cost, and payments, and a number of factors in setting an update payment for the hospitals. And I can't remember if you were here when I was talking to Mr. Kind. The Commission, for the last couple years, has made positive payment updates for hospitals the last couple of years. Over 10 years—or longer, even—the Commission has made recommendations with respect to rural payment that have increased payments to rural hospitals, trying to address some of the issues that you raise.

Now, all that said, I also want to say something else, which is in 2012 the Commission did—and this was an exchange I believe I had with Mr. Smith, which was when you think about the supports, think about, you know, how—and particularly the Congress is always working with a limited dollar. Think about where that dollar is going to make the greatest difference. If you just say all—increases to all rural, you are increasing payments for a hospital that sits right next door to, you know, an urban area, and a hospital that is 50, you know, miles out on a hilltop. And so, there are other ways to think about how the support is provided.

And the other thing I think is just a fact of life—and it is for urban and rural hospitals, but to Mr. Smith's point, and to your point, it can mean a lot more in a rural area—is if admissions continue to fall, these hospitals are—urban and rural—are going to have to rethink their mission. And an idea that seems to be floating around some of the urban—or rural areas, sorry, that I have talked to people about is the notion of whether—is it a full inpatient hospital that you need at that point, or do you need something more like an emergency room/urgent care type of thing.

Because, you know, your point is a heart attack, to go 21 miles or more miles, I get your point. But what about a routine, you know, inpatient hospital service, if, in fact, the admissions are declining? It is going to be struggle for hospitals, and particularly for rural areas, to support hospitals if admissions continue to decline.

Ms. JENKINS. Okay, I agree. Another study I saw from the National Rural Health Association, it reports that 283 additional rural hospitals are on the brink of closure, just shutting their doors. And this means, you know, for these communities, they are not going to have the comprehensive local care that they need to survive. And, of course, I think you understand when rural hospitals close there is a domino effect, and employers are affected, communities, families, and the like.

Just quickly, where are folks that call rural America home receive needed health care—where are they supposed to receive the needed health care, if we see these rural hospitals closing?

Mr. MILLER. And I think it goes back to a point that I was making a minute ago, which is, again, how many fully comprehensive hospitals do you need for any given set of miles? I absolutely agree that you need some set of comprehensive care. But if the—we are supporting hospitals that are in rural areas that are very close to one another.

And a question for the Congress, particularly with a limited dollar, is if there was a consolidation there, one hospital, it might be more financially viable. It might have higher quality. And it could be that we need to have these conversations about a different community saying, okay, they will have an emergency facility, and this—you will have some consolidation for the hospital, and then an emergency facility to serve where you don't have a full hospital. Sorry.

Chairman BRADY. Thank you, Ms. Jenkins.

Mrs. Noem, you are recognized.

Mrs. NOEM. Thank you, Mr. Chairman, and thank you for allowing me to be a part of this Committee hearing today. I appreciate the ability to sit at the dais.

Mr. Miller, I am from South Dakota, so home of where the deer and antelope play, and it is a long ways to drive anywhere. We have had many consolidations already, but yet it is still a struggle for our people to get access. So I wanted to visit with you a little bit about the unique challenges that some of our rural providers face. And in your testimony you stated that the last time MedPAC looked at rural Medicare beneficiaries' access to care, you found that the mix of—for rural providers was incoherent, and that it lacks a common framework.

So, in South Dakota, the providers that I meet with, they would agree with you. They tell me that they are forced to chase after dollars many times, using a bizarre mix of adjusters and add-ons, which only adds to their administrative burdens. And, to make matters worse, CMS often carves real providers out of payment reforms, leaving them behind.

So, as the committee considers payment reform, can you suggest how we can improve the situation for rural providers?

Mr. MILLER. Okay. I mean we are having a, you know, theoretical or principle conversation.

Mrs. NOEM. Absolutely.

Mr. MILLER. Again, focus your dollar, first and foremost, on isolated, low volume, okay? Because isolated means there is no other alternative, low volume means I can't support my costs. And so, you know, if there is a dollar the Congress has, that first dollar should go to those types of facilities. I hate to keep harping on this. One that is right next door to an urban area, maybe the need is not as great.

And I have to tell you my rural commissioners, when we went through this—and I don't want you to think we don't look at rural every year. We just did a comprehensive thing in 2012. I mean the rural commissioners were saying, "Rural isn't rural isn't rural." It differs, depending on how far and how frontier you get.

A second principle that the Commission talked about was the notion that you can provide supports, but you can either do it open-ended or in a fixed way. If you provide an open-ended support, you are probably giving them—and there is evidence of this, that costs go up. And so then your supports have to chase that cost over time. If you give a fixed support, the provider continues to have some pressure to contain their cost. So we would say think about that.

It gets into individual measures. The empirical basis for some of the adjustments is questionable, and gets into a little bit more technical conversation. But there are things where, you know, the analysis would say, "This is how much support you should give," and there is this much, and you get kind of funny distortions, or people chasing what you said.

Mrs. NOEM. Yes.

Mr. MILLER. Because I have talked to rural people, and they say the same thing that you are saying.

On the quality front, there is a dilemma. And I think that is what you meant by leaving them out of reform——

Mrs. NOEM. Payment reforms.

Mr. MILLER [continuing]. Or at least part of it is, you know, they can't play as much in the quality. And this is a dilemma, in the sense that if you have a small—it is hard to get an accurate measure. You get real noisy quality results.

I mean the Commission has talked about accumulating multiple years of data. If rural providers are willing to be treated as a group, you can consolidate them and say, "Judge us on our net performance" is the way to try and jump those kinds of fences.

Mrs. NOEM. Have you come to a conclusion on that? Do you think that would be accurate? Or have you floated that idea to rural providers to see if they would consider——

Mr. MILLER. We have certainly discussed that in principle in our reports. I mean, obviously, when somebody comes to you and says, "Okay," it is the two of us, it is hard, you know, for us to say that one is noisy, that one isn't noisy. We would have to see the thing to know.

And, actually, there is also some people who are trying to organize networks of rural providers and ACOs, as well.

Mrs. NOEM. Okay.

Mr. MILLER. You know, again, kind of accumulating a number of rural providers.

Mrs. NOEM. Okay, thank you.

I yield back, Mr. Chairman.

Chairman BRADY. Thank you, Mrs. Noem.

Mr. Crowley, you are recognized.

Mr. CROWLEY. Thank you, Mr. Chairman, and thank you for allowing me to sit on your committee hearing today.

I know this Subcommittee is looking primarily at hospital policy issues, and so I am glad to have the opportunity to participate in the discussion.

Mr. Miller, as you know, I resent—represent part of New York City, home to a number of world-class medical institutions, from teaching hospitals to cancer centers to medical schools. So I have had many discussions with health care systems on how much they rely on Medicare payments, just to be able to provide care to their populations.

Today I want to focus on the issue of graduate medical education, or GME. At the start there is a point that I want to make clear. Training our nation's doctors has long been a shared responsibility between individual teaching hospitals and the Federal Government. And that is because it is a shared benefit. The teaching hospitals may be the one receiving the payment to offset a portion of their cost, but it is the whole country that benefits from more well-trained doctors.

Ensuring that our academic medical centers receive adequate funding through GME is not just an issue for that hospital. It is an issue for our entire nation. The doctors who are trained in New York, for example, going to practice all over the country. And they practice in every specialty, too, from primary care and family medicine to the most targeted specialties. So, I really do think that the discussion of how we pay for graduate medical education can't just start and stop with dollars and cents at a single hospital. It has to consider the investment that we make in caring for our senior citizens, and in our nation's entire health workforce.

Part of that investment is also in the highly complex and costly patient care missions that teaching hospitals undertake. They run advanced trauma centers and burn units, and they see more complex patient cases. They treat patients with rare and difficult diseases like Ebola. And that helps train future doctors in all those areas. Graduate medical education payments designed—were designed by Congress to reflect all these undertakings, beyond just the explicit costs you may see on paper. And teaching hospitals will continue to take on new challenges.

Mr. Miller, in your testimony you say that to provide our health care delivery system, we need to "ensure that our residency programs produce the providers and skills necessary to integrate care across settings, improve quality, and use resources efficiently." Well, from what I have seen, our teaching hospitals are tackling that challenge head on.

One of the things we have strived to do with the Affordable Care Act are—the permanent doc fix and other initiatives, is to highlight the importance of coordinated care, preventative care, and other quality measures. We all recognize that care does not just happen within the four walls of a hospital, and it shouldn't. Teaching hospitals are doing more to train residents in community care settings, and to focus on giving residents the skills they need to provide ex-

actly the kind of care that MedPAC and others have called for. And they have to use resources efficiently, because they are getting hit with cuts from all sides.

I would argue that a sufficient investment in GME, not cutting and redirecting funding away, is what enables hospitals to do all these things. Do you disagree? Why can't we accomplish these goals without cutting funding?

Mr. MILLER. The Commission has a policy on GME, or a recommendation on GME, that I can take you through. The Commission's policy took a block of the current IME dollars and allocated them in a different way. It didn't reduce them.

But I also would say, in response to at least some of the points that you are making, as it stands—we are talking about $3.5 billion—the accountability for that dollar doesn't exist. The notion that it is being devoted to teaching and, you know, training for, you know, a reformed delivery system, or whatever the case may be, currently we have no accountability for it. It is just a dollar that flows into the hospital. It can be used for anything.

So I think we would agree, in the sense of saying you take the dollars that exist, you allocate them differently—which I can take you through—and you target them to hospitals—and this is the part where you may disagree, but just to be clear—and other providers who are running graduate medical education programs that are more comprehensive in team-based care, evidence-based medicine, and also alternative sites of care, where they are trained, in addition to the hospital. But we didn't talk about eliminating the dollar.

Mr. CROWLEY. I appreciate that. I can appreciate accountability, as well. And I think you appreciate the complexity, in terms of the teaching of a modern doctor today.

As a New Yorker, we can chew and walk gum [sic] at the same time, and I think we can do more and do it better. I agree with you on that.

I believe we need strong investment in graduate medical education, like raising the outdated cap on the number of residents that Medicare supports. And I am just finishing, Mr. Chairman. I have a bill to do just that with my good friend and my colleague, Dr. Boustany, in a bipartisan way, and a large bipartisan support for that, Mr. Miller, as well.

Mr. Chairman, I know you have talked about putting together legislation to help support our nation's hospitals, and I hope you will consider this issue as a priority to include. I also hope you will recognize the hurtful impact of cuts to GME program, not only in the hospitals that rely on this federal contribution, but on the doctors that train there, on the patients who they will see throughout their careers.

I look forward to working with you and the committee to ensure that we continue to provide needed funding to our nation's teaching hospitals. And, with that, I yield back.

Chairman BRADY. Thank you, Mr. Crowley.

Mr. Renacci, you are recognized.

Mr. RENACCI. Thank you, Mr. Chairman. And thank you, as well, for allowing me to be part of this Committee hearing this morning.

Dr. Miller, your testimony and the June MedPAC Report raised some critical issues, especially as they relate to improving hospital payment policy. The ACA included a new program, which is addressed in the report, aimed at reducing unnecessarily hospital readmissions. The program is known as the Hospital Readmission Reduction Program. The goal of this program is one that I and many of my colleagues support. In fact, it is estimated that nearly 18 billion per year is wasted on avoidable readmissions that—18 billion per year is wasted on avoidable admissions of Medicare patients alone. Reducing these preventable readmissions would reduce costs and improve outcomes.

However, the implementation of this program has been problematic, especially for those hospitals serving low-income patients. Dr. Miller, can you explain the correlation between hospitals serving low-income patients and readmission penalties? Is there a direct correlation, in your opinion? And do you have some concerns?

Mr. MILLER. Yes, and we have some fixes, as well. So there is a relationship. Depending on what you mean by direct, it—this is more a subtlety. There seems to be a critical mass. So, you know, you get more poor people, you don't see a lot of change in readmission rates. Then you hit a certain level of having poor people as a percentage of your hospital, and then you start to see higher readmission rates. There is a relationship. It is not directly one to one, but there is a relationship, and we have laid this out in the report, and we, you know, fundamentally agree with the statement that you are making.

The Commission ended up saying this. And what we ideally want—we have made some other recommendations to refine the measure—what we really want is we don't want the penalty dollar. We want the hospital to avoid the readmission. It is better for the patient. You know, the program saves money by avoiding the readmission. You know, the penalty is really just a motivation. And, actually, a very small amount of dollars are actually driving relative change. And so I am hoping that this is headed in a positive direction.

With respect to the proportion of poor people, this is what we would do. We would not adjust the measure. So if a hospital has a good or a bad readmission rate, that remains on paper, because we think hospitals need to be focused on that, the public needs to be aware of it. Whether you are rich or poor, you should know what your readmission rate is in a given hospital that you are about to walk in the door.

However, mitigate to some extent the effect of the penalty. And the way you do that is you say that the penalty will be mitigated based on how many proportions of poor people, and we would put hospitals in a category and say lots of poor people, the penalty is not as heavy, few poor people, the penalty is heavier.

And then, within any category, you have to outperform your colleagues. So if I am a hospital with lots of poor people and I do well on readmissions, you know, I am spurring other hospitals to improve their performance. So we would mitigate the effect, but we would do it through the penalty, not adjust the measure.

Mr. RENACCI. But you do agree, then, that hospitals that have these lower-income patients inevitably are going to have these readmissions more than other hospitals.

Mr. MILLER. Yes, but we also believe that there are hospitals out there with lots of poor people who have relatively low readmission rates, and change can occur. And we would mitigate the penalty to help them along. But yes, we agree with the statement you made.

Mr. RENACCI. All right. Well, I share your concerns that many of the hospitals—especially in my district—that serve the most needy are being unfairly penalized under the Hospital Readmission Reduction Program.

I have introduced H.R. 1343, the Establishing Beneficiary Equity in the Hospital Readmission Program, which would require risk adjustment for socio-economic factors when calculating hospital penalties, ensuring these critical hospitals can continue to take care of the least among us without being penalized for doing so, and I thank you for your word MedPAC has done on this issue.

And I yield the remainder of my time.

Chairman BRADY. Thank you, Mr. Renacci. You know, going—as you have noticed, we have a hearing on competition next week, focusing on rural disparities. We are going to be discussing GME and hospital payment reform, in the hopes of bringing—through the fall, in the hopes of bringing some legislation to the floor and to the committee there. Today's hearing was very helpful and insightful, as we go forward with that.

So, Dr. Miller, thank you for your testimony. Appreciate your continued assistance. We will need it, getting answers to the questions that were asked by those on the committee.

And as a reminder, any Member wishing to submit a question for the record will have 14 days to do so. And if any Member does, Doctor, I ask that you respond in writing in a timely manner, which I know you will.

Again, thank you. With that, the committee is adjourned.

[Whereupon, at 11:40 a.m., the subcommittee was adjourned.]

[Public Submissions for the Record follows:]

Association of American Cancer Institutes, statement

Association of American Cancer Institutes

Statement by the Association of American Cancer Institutes for the

Subcommittee on Health

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

Medicare Payment Advisory Commission (MedPAC) Hospital Payment Issues

July 22, 2015

The Association of American Cancer Institutes (AACI), representing 95 of the nation's leading academic and free-standing cancer centers, appreciates the opportunity to submit this statement for the record to the subcommittee on the July 22 Medicare Payment Advisory Commission (MedPAC) hearing on hospital payment issues.

Site-neutral policy recommendations have been made recently in regard to hospital outpatient departments and physician offices, with the suggestion to equalize Medicare payments. This recommendation is of concern to our nation's cancer centers. National Cancer Institute-designated cancer centers and academic research institutions are the primary source of new discoveries into cancer's causes, as well as the prevention, diagnosis, and treatment of cancer.

Cancer centers develop and deliver state of the art therapies and provide comprehensive care, from prevention to survivorship, to patients. Our nation's cancer centers are engaged in their communities, providing timely information to healthcare professionals and the general public about cancer prevention and screening measures, conducting research and developing new treatments in their labs, and serving diverse and often underserved and understudied patient populations.

A recent study prepared for the American Hospital Association determined that relative to patients treated in physician offices, cancer patients receiving care in hospital outpatient departments are often more likely to be:

- Minority or underserved patients

- Uninsured, self-pay, charity care or Medicaid patients
- Residing in areas of poverty, with lower household income and lower educational attainment
- Burdened with more severe chronic conditions and comorbidities

Our nation's cancer centers treat some of the sickest and costliest patients through multidisciplinary teams with expertise in specific cancer types. These high-caliber teams are at the forefront of offering specialized therapeutic strategies beyond traditional chemotherapy, including immunotherapies and personalized medicine. Cancer patients require particular treatments in facilities where immediate assistance from nurses and other caregivers can be provided. Compared with physician-based oncology practices, hospital outpatient departments are equipped to serve patients with the potential for high complications, where immediate assistance from appropriate hospital staff can be provided. Such hospitals provide more comprehensive services to treat complex patient needs including social support services, palliative care, on-site pharmacy services, and nutrition assistance. The delivery of care at our nation's cancer centers is unparalleled.

AACI cancer centers face persistent reimbursement challenges and added costs due to state and federal mandates shift an additional burden onto cancer centers. Hospital-based programs assume more responsibilities and fulfill more stringent requirements than do physician offices, including licensing, accreditation, and regulatory requirements. Unlike the physician fee schedule, hospital costs are verified by audited cost report and claims data. Care provided in the hospital outpatient setting is cost-effective, and further reductions to payments could threaten patient access to essential services.

Conclusion

The institutions represented by AACI strongly object to site-neutral reimbursement proposals performed in a budget neutral manner at the expense of cancer centers and other hospital-based programs. The future of cancer care relies on the highly-skilled teams based at our nation's cancer centers. Changes

in Medicare payment rules at the cost of cancer centers could diminish cancer services at our nation's cancer centers and, by extension, the well-being and prospects for recovery of millions of cancer patients.

America's Essential Hospitals, statement letter

The Honorable Kevin Brady
Chair
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

The Honorable Jim McDermott, MD
Ranking Member
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

August 5, 2015

Statement for the hearing record: Hearing with the Medicare Payment Advisory Commission to discuss hospital payment issues, rural health issues, and beneficiary access to care

Submitted electronically to: waysandmeans.submissions@mail.house.gov

Dear Chairman Brady and Rep. McDermott:

On behalf of America's Essential Hospitals and its more than 250 member hospitals and health systems, I thank you for the opportunity to provide our thoughts regarding the July 22, 2015, hearing on Medicare hospital payment issues. Our member hospital systems are united by a commitment to serve all patients, including the most vulnerable, with the best health care possible. Essential hospitals are also primary providers of essential community services that touch all people, including trauma and burn care, disaster response, public health, preventive services, and medical education.

Our comments are on four specific areas: Medicare disproportionate share hospital (DSH) payments, the Hospital Readmissions Reduction Program (HRRP), Medicare indirect medical education (IME) payments, and issues related to Medicare payment for short inpatient stays.

essentialhospitals.org

AMERICA'S ESSENTIAL HOSPITALS
1301 Pennsylvania Ave NW Ste 950
Washington DC 20004

t: 202.585.0100
f: 202.585.0101
e: info@essentialhospitals.org

Medicare DSH

To maintain their financial stability, members of America's Essential Hospitals rely on a patchwork of federal, state, and local support, including Medicare DSH payments. **Because our hospitals on average operate at a loss—an average negative 3.2 percent operating margin in 2013—scaling back any component of that support severely challenges essential hospitals' ability to serve their communities.**
Section 3133 of the Affordable Care Act (ACA) cut Medicare DSH funding by $22 billion from fiscal years 2014 to 2019. While DSH hospitals continue to receive 25 percent of their Medicare DSH payments as a per-discharge adjustment, the remaining 75 percent is decreased to reflect the change in the national uninsurance rate and distributed based on uncompensated care burden. This change was intended to better incorporate uncompensated care into the Medicare DSH formula to better target support at hospitals with the greatest need. America's Essential Hospitals has long supported this approach and continues to work with the Centers for Medicare & Medicaid Services (CMS) to ensure the targeting is conducted in a fair and accurate manner.

But we are concerned about the sustainability of continued reductions to the aggregate uncompensated care–based DSH payments that are occurring as coverage continues to expand and the national uninsurance rate falls. We urge the committee to evaluate the appropriateness of continuing these Medicare DSH cuts in light of the following points.

The aggregate amount of uncompensated care payments CMS has proposed for fiscal year (FY) 2016—$6.4 billion—incorporates a nearly 30 percent reduction from FY 2013 levels. This amount will continue to decline with the national uninsurance rate. Hospitals in states that have not expanded Medicaid are not experiencing the drop in uncompensated care that hospitals in expansion states have seen. The cuts have even challenged essential hospitals in expansion states because of continuing high levels of uncompensated care and the vulnerable people they serve.

Further, the CMS's current Medicare DSH methodology relies on an imprecise measure of hospital uncompensated care. Under the methodology, CMS determines a hospital's qualifying uncompensated care burden by estimating the hospital's percentage of the total uncompensated care costs incurred by all DSH hospitals. To date, CMS has concluded that due to shortcomings of the Medicare cost report S-10 worksheet, it must deviate from the common definition of uncompensated care and instead use a proxy to estimate hospital

uncompensated care costs. CMS notes the proxy is an interim measure and proposes to continue to monitor alternative proxies and data sources.

Given the substantial negative impact of the Medicare DSH cuts on essential hospitals—in both expansion and non-expansion states—and the shortcomings in data needed to accurately calculate uncompensated care, America's Essential Hospitals would support thoughtfully crafted legislation to stop further aggregate cuts to Medicare DSH. Since the hearing on July 22, Rep. Kenny Marchant introduced legislation changing the ACA's Medicare DSH cut policy by directing new funding to hospitals in states that have not expanded Medicaid under the Affordable Care Act. America's Essential Hospitals is currently analyzing the impact of this legislation and will provide feedback to the committee at a future time.

Medicare HRRP

Section 3025 of the ACA mandated the creation of the Medicare HRRP. The program was designed to give hospitals a financial incentive to reduce avoidable readmissions. While we agree with the general intent of the program, the current readmissions measures do not accurately reflect quality of care because they do not account for patients' complex social and economic circumstances that exist outside a hospital's control and drive readmissions. As the Medicare Payment Advisory Commission (MedPAC) noted in its written testimony: "Hospitals' readmission rates and penalties are positively correlated with their low-income patient share."

Because the HRRP fails to adjust for sociodemographic factors that lead to readmissions, many essential hospitals will suffer penalties unrelated to the actual quality of the care they provide. This reduction in funding will create a vicious cycle, making it even more difficult for hospitals to help patients overcome disadvantages and, in turn, further increasing readmissions. As noted above, most essential hospitals operate on narrow or negative margins and cannot absorb additional funding cuts. HRRP penalties could force some hospitals to make difficult decisions regarding the services they provide, the people they employ, and their reinvestments in the community.

America's Essential Hospitals supports legislation drafted by Rep. Jim Renacci: H.R. 1343, Establishing Beneficiary Equity in the Hospital Readmission Program Act. H.R. 1343 would mitigate the unequal treatment of hospitals in a two-stage approach. First, for fiscal years 2016 and 2017, the bill would require CMS to make a risk adjustment that accounts for both a hospital's

proportion of inpatients who are full-benefit, dually eligible individuals; and the socioeconomic status of the patients a hospital serves. Second, for fiscal years after 2017, the bill would require CMS to risk adjust the readmission measures based on findings from the Improving Medicare Post-Acute Care Transformation Act of 2014, and also require MedPAC to report on the appropriateness of the program's 30-day threshold for readmissions. America's Essential Hospitals remains open to solutions other those in H.R. 1343 to limit the negative impact HRRP has on essential hospitals and their vulnerable patients.

Medicare IME

Members of America's Essential Hospitals commit to training the nation's future health care workforce. **In fiscal year 2013, our more than 250 member hospitals trained, on average, 254 physicians per hospital, which is 14 times as many as the average number trained at other U.S. teaching hospitals**.

Graduate medical education (GME) payments cover the direct cost of physician training. Medicare IME payments are designed to cover the indirect higher costs of operating a teaching hospital. The Balanced Budget Act of 1997 capped the number of residency slots for which Medicare can reimburse teaching hospitals. **These caps, based on training levels when Congress passed the 1997 law, are long outdated and have not increased with training needs. Nevertheless, to further their missions and despite financial stress, many essential hospitals train above their Medicare caps.** The funding shortfall for each resident trained beyond a hospital's cap creates additional financial strain on essential hospitals.

America's Essential Hospitals would support legislation to remedy the ongoing problem presented by an inadequate number of physician residency slots funded by GME, particularly for public and nonprofit teaching hospitals. Since the hearing on July 22, Chairman Brady introduced legislation that would substantially change the formula by which Medicare distributes funds for IME. America's Essential Hospitals is analyzing the legislation and looks forward to discussing this important issue further with the committee.

Medicare Short Stay Policy

In its FY 2014 inpatient prospective payment rule, CMS first announced the "two-midnight" policy. But in response to concerns raised by providers and

Congress, the agency put in place am enforcement ban on parts of the regulation and has repeatedly extended the ban. Most recently, CMS extended the ban until September 30, 2015, based on a requirement in the Medicare and CHIP Reauthorization Act of 2015. **The repeated extension of the enforcement ban indicates that the agency, hospitals, and other stakeholders are not prepared to implement the two-midnight policy. America's Essential Hospitals supports further extending this ban until appropriate changes to the two-midnight policy are enacted.**

In CMS' Outpatient Prospective Payment System proposed rule, the agency responded to stakeholders' concerns about the impact of the policy on clinicians' judgment by proposing to revise its short stay policy. This proposal would allow for Medicare reimbursement for short inpatient stays in cases where the admitting physician believes the inpatient admission is medically necessary. **We believe that this is a step in the right direction, as ultimately only a physician can decide which setting of care is most appropriate for a patient. This proposed change, in conjunction with measures to limit RACs' ability to overturn admission decisions made by physicians, are important steps in addressing concerns about the impact of the policy on hospitals and their ability to provide an appropriate level of care to patients.**

Since the hearing, Chairman Brady introduced the "Medicare Crosswalk Hospital Code Development Act." America's Essential Hospitals is analyzing the legislation and looks forward to providing feedback to the committee.

Thank you again for the opportunity to comment on these important payment policies. We look forward to providing more feedback regarding recently introduced legislation in several of these areas.

Sincerely,

/s/

Bruce Siegel, MD, MPH
President and CEO

National Association of Chain Drug Stores, statement

Statement

Of

The National Association of Chain Drug Stores

For

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

Hearing on:
The Medicare Payment Advisory
Commission (MedPAC)

July 22, 2015
10:00 A.M.

B-318 Rayburn House Office Building

National Association of Chain Drug Stores (NACDS)
1776 Wilson Blvd., Suite 200
Arlington, VA 22209
703-549-3001
www.nacds.org

The National Association of Chain Drug Stores (NACDS) thanks Chairman Brady, and the members of the Subcommittee on Health for the opportunity to submit the following statement for the record regarding the Medicare Payment Advisory Commission (MedPAC) and the discussion of hospital payment issues, rural health issues, and beneficiary access to care. NACDS and the chain pharmacy industry are committed to partnering with Congress, HHS, patients, and other healthcare providers to improve the quality and affordability of healthcare services.

NACDS represents traditional drug stores and supermarkets and mass merchants with pharmacies. Chains operate more than 40,000 pharmacies, and NACDS' chain member companies include regional chains, with a minimum of four stores, and national companies. Chains employ more than 3.2 million individuals, including 179,000 pharmacists. They fill over 2.9 billion prescriptions yearly, and help patients use medicines correctly and safely, while offering innovative services that improve patient health and healthcare affordability. NACDS members also include more than 850 supplier partners and over 60 international members representing 22 countries. For more information, visit www.NACDS.org.

The national physician shortage coupled with the continued expansion of health insurance coverage in 2015 will have serious implications for the nation's healthcare system. Access, quality, cost, and efficiency in healthcare are all critical factors – especially to the medically underserved and those living in rural areas. Utilizing pharmacists can help ensure access to requisite healthcare services for these vulnerable populations.

As the face of neighborhood healthcare, community pharmacies and pharmacists provide access to prescription medications and over-the-counter products, as well as cost-effective health services such as immunizations and disease screenings. Retail pharmacies are often the most readily accessible healthcare provider. Nearly all Americans (94%) live within five miles of a community retail pharmacy. Recognition of pharmacists as providers under Medicare Part B would help to provide valuable and convenient pharmacist services to millions of Americans, and most importantly, to those who are already medically underserved or reside in rural areas. Access to these types of services is especially vital for Medicare beneficiaries as nearly two-thirds are suffering from multiple chronic conditions. Through personal interactions with patients, face-to-face consultations, and convenient access to preventive care services, local pharmacists are helping to shape the healthcare delivery system of tomorrow—in partnership with doctors, nurses, and others.

In addition to helping reduce post-acute care issues related to medication non-adherence, retail community pharmacists can provide high quality, cost efficient care and services. However, the lack of pharmacist recognition as a provider by third party payors including Medicare and Medicaid has limited the number and types of services pharmacists can provide, even though fully qualified to do so. For this reason, we support H.R. 592, the "Pharmacy and Medically Underserved Areas Enhancement Act," which would allow Medicare Part B to utilize pharmacists to their full capability by providing those underserved beneficiaries with services not currently reaching them (subject to state scope of practice laws).

The medically-underserved population includes seniors with cultural or linguistic access barriers, residents of public housing, persons with HIV/AIDS, as well as rural populations and many others. Significant consideration should be given to innovative initiatives within the medically-underserved population to enhance healthcare capacity and strengthen community partnerships to offset provider shortages and the surge in individuals with healthcare coverage. It is especially important that underserved beneficiaries have continued access to a provider for follow up and to ask questions; oftentimes this is the community pharmacist. NACDS urges the adoption of policies and legislation that increase access to much-needed services for underserved Americans, such as H.R. 592. This important legislation would lead not only to reduced overall healthcare costs, but also to increased access to healthcare services and improved healthcare quality for underserved patients, including those in transitions of care.

Conclusion

NACDS thanks the subcommittee for consideration of our comments. We look forward to working with policymakers and stakeholders on looking to find ways to improve care for Medicare patients who are underserved or live in rural areas.

National Rural Accountable Care Organization, letter

August 5, 2015

The Honorable Paul Ryan, Chairman
House Ways and Means Committee
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Sandy Levin, Ranking Member
House Ways and Means Committee
1106 Longworth House Office Building
Washington, DC 20515

Dear Chairman Ryan and Ranking Member Levin:

The National Rural Accountable Care Organization is organizing rural providers across the country under the Medicare Shared Savings Program (MSSP) to redesign their delivery systems to provide better care at a lower cost. We currently operate 6 Accountable Care Organizations (ACOs) with 30 rural health systems covering 9 states. Supported by the ACO Investment Model (AIM) opportunity, we will be submitting applications on behalf of an *additional* 149 rural health systems in 32 states to form 26 Medicare ACOs in 2016. These 179 rural health systems support approximately 500,000 Medicare Fee-For-Service beneficiaries with a total annual spend of more than $5 billion. In addition, our non-profit, the National Rural Accountable Care Consortium, is in discussions with the Center for Medicare and Medicaid Innovation (CMMI) to set up care coordination and quality improvement and reporting programs for an additional 300 rural health systems that are not yet ready for Advanced Payment Models under the Transformation of Clinical Practice Initiative (TCPI). When you combine the two programs listed above, we will be supporting more than 20% of the 1,971 rural community health systems identified by the American Hospital Association to achieve the three-part aim, with achievable goals of improving quality by 20% and reducing cost by 10%. If successful, we will reduce Medicare spending for rural beneficiaries by $500 million per year, and simultaneously strengthen the financial viability of rural health systems.

First, we would like to recognize the extraordinary support and commitment for rural healthcare reform from individuals at the Department of Health and Human Services and the Medicare Payment Advisory Commission (MedPAC). We are actively engaged with them in developing a better future and a better healthcare and payment system for rural beneficiaries. We deeply appreciate the time and attention they are paying to rural health.

As you consider policy and alternative payment models and options for rural America, we ask you to consider the following:

1. Provide positive incentives for rural clinicians to participate in Medicare ambulatory quality reporting programs, such as the Physician Quality Reporting System (PQRS), targeting improvement in quality and access for rural beneficiaries.
2. Remove negative incentives for rural beneficiaries to use their rural health system to improve quality and enable rural Patient Centered Medical Homes (PCMH), which reduces costs to the Medicare Trust Fund.
3. Provide positive incentives for Rural Health Clinics (RHCs) to provide the Initial Preventive Physical Exams, Annual Wellness Visits, Transition of Care Management and Chronic Care Management Services to improve quality while lowering costs.
4. Provide positive incentives for rural Emergency Departments (EDs) and Emergency Medical Services to act as an integral member of the rural primary care team, including payment for provision of primary care visits when preferred by the beneficiary, in addition to allowing them to bill for the Initial Preventive Physical Exams, Annual Wellness Visits, Transition of Care Management and Chronic Care Management Services and for collaboration with rural Care Coordinators.
5. Revise the spending calculations used in the MSSP for Critical Access Hospitals (CAHs), RHCs, and Federally Qualified Health Centers (FQHCs) to improve accuracy and exclude special payments.
6. Support the Rural ACO Improvement Act of 2015, which appropriately attributes patients to the Nurse Practitioners and Physician's Assistants who are the primary care providers for many rural beneficiaries.
7. Support the REACH Act to preserve local access to emergency, short stay, skilled nursing, outpatient and primary care in communities that are too small to continue to support an acute care hospital.

Provide positive incentives for rural clinicians to participate in Medicare ambulatory quality reporting programs, such as the PQRS, to improve quality and access for rural beneficiaries. In order to achieve the Secretary's goal of tying some portion of 90% of provider payments to cost and quality, rural clinicians will need to be included. While ACOs are currently reporting quality scores above 70%, we find rural providers are averaging slightly below 60% when they enter the program, indicating a potential gap in quality. We are deeply concerned about how lower quality scores of patients coming from rural primary care providers will affect their ability to access care from urban specialists whose income will be adjusted downward for low quality patients under the Medicare Access and CHIP Reauthorization Act (MACRA). We find the PQRS and ACO measures that we currently report to be appropriate and achievable for rural providers, and focus their energy on implementing process improvements and evidence-based medicine practices that are proven to improve outcomes, lower cost and enhance patient satisfaction. We applaud CMS for proposing that rural providers begin

reporting HCPCS codes on their bills in 2016 to enable value-based payments, and the potential participation in PQRS. We support the implementation of voluntary enrollment of RHCs and FQHCs in PQRS, with no penalties for lower performance, similar to solo practice physicians, but with the potential to earn incentive increases in the rates that reward quality performance.

Remove negative incentives for rural beneficiaries to use their rural health system to improve quality, enable Medical Homes and reduce costs to the Medicare Trust Fund. RHCs and CAHs are reimbursed based on cost, and cost per beneficiary is calculated based on total cost divided by number of beneficiaries. Rural providers have high fixed costs, therefore, decreases in volume do not result in proportional decreases in costs and conversely increases in volume result in decreases in per beneficiary cost.

To illustrate that point, if CAH discharges are 75% Medicare, the CAH's allowable costs are $5,000,000, and there are 1000 patient days, Medicare pays the CAH 75% x $5,000,000 x 101% = $3,787,500 or **$3,786 per patient day**. If the CAH doubled its average daily census from 3 to 6, and the incremental cost was only 15%, Medicare would pay the CAH $4,355,625, or **$2,178 per patient day**. Conversely, if the number of patient days decreases to 500, and the incremental cost drops 15%, the average cost per patient day would increase to **$6,438.75 per patient day**. The same is true for outpatient services, which account for almost 75% of CAH revenue.

Working against the obvious benefit of maximizing *local* appropriate utilization of the cost-reimbursed healthcare system, current policy has substantial penalties for beneficiaries who use their local rural provider. Beneficiaries are required to pay 20% of charges for outpatient and ambulatory services, which frequently exceeds the amount of out-of-pocket costs for similar Prospective Payment System (PPS) facilities. MedPAC has reported that beneficiaries pay an equivalent of 50% coinsurance for CAH outpatient services, as compared to the PPS rate. To date, much of this has not been transparent to beneficiaries due to the high prevalence of Supplemental Insurance and general opacity of healthcare pricing. As we move toward more pricing transparency, consumerism and limitations of copay and deductible waivers under MACRA, we anticipate that more beneficiaries will choose lower cost facilities when feasible to reduce out-of-pocket expenses. As a result, we expect rural market share to decrease, and as a result, rural per beneficiary spending to increase. As rural volumes decrease, per beneficiary costs will increase, which will drive more patients out of the system. Policies that encourage rural patients to utilize their local health system, such as capping all copays and deductibles at the corresponding PPS rate to create parity, and waiving copays and deductibles for rural primary care services as seen in FQHCs, will go far to reduce the cost of rural Medicare beneficiaries to the Medicare Trust Fund, improve access and strengthen the financial viability of the rural health systems.

Provide positive incentives for RHCs to provide the Initial Preventive Physical Exams, Annual Wellness Visits, Transition of Care Management and Chronic Care Management Services to improve quality and lower costs. Annual Wellness Visits and Initial Preventive Physical Exams are critical for keeping seniors healthy and avoiding costly complications by facilitating early intervention, yet our claims data indicates that 40% of our rural health systems are **not** currently performing annual

wellness visits. Only 11.6% of our beneficiaries have received these visits this year, with 71.5% of those patients seen in fee-for-service clinics. Fee-for-service clinics can invest additional resources to frequently accomplish these visits while the patients have presented for other issues, and can bill separately to pay for the cost. RHCs and FQHCs cannot bill for the visit in addition to the All Inclusive Rate, so if they do this work at all they do it at their own expense with no compensation to invest in resources to get the work done. Attempts to get rural patients to come into the clinic solely for the Annual Wellness Visit have been largely unsuccessful.

CMS has proposed the ability for RHCs to bill for Chronic Care Management in addition to the All Inclusive Rate in the 2016 Physician Fee Schedule, which we strongly support. We propose that this exception is also extended to Annual Wellness Visits and Initial Preventive Physical Exams.

Provide positive incentives for rural EDs and Emergency Medical Services to act as an integral member of the rural primary care team, including payment for provision of primary care visits when preferred by the beneficiary, in addition to allowing them to bill for the Initial Preventive Physical Exams, Annual Wellness Visits, Transition of Care Management and Chronic Care Management Services and for collaboration with rural Care Coordinators. The rural ED is an integral part of the rural primary care system. We average 20-24% more ED visits than Medicare Fee-For-Service. Approximately 50% of them are level one visits, which are likely non-emergent primary care. Not coincidentally, we average 59-64% of the hospital admission rate from the ED. Many rural beneficiaries cannot get to the ED during clinic hours, and after-hours care or advice is rarely available. Rural emergency rooms are accessible 24/7, have little or no waiting times, are well-staffed and operated, and thanks to Supplemental Insurance are usually at no cost to the beneficiary. In other words, convenient, high-quality, and low-cost or free – a consumer's dream.

Rural Emergency Medical Services are also often under-utilized with fixed costs and can play a very important role in providing efficient home visits for chronically ill and frail Medicare beneficiaries when partnered with the rural community health system.

We support a re-evaluation of how these providers can be compensated for better integration into the rural primary care system, in addition to considerations of how we can utilize their excess capacity to provide more access to important primary care services. In some situations, the rural ED may be the best home for a community-based care coordination service. Many rural communities only have enough Medicare beneficiaries that require Chronic Care Management to be supported by a single care coordinator. Many of the patients that need this service are frequent users of the ED, making the rural ED a desirable location for this service.

Revise the spending calculations used in the MSSP for CAHs, RHCs, and FQHCs. In order to move rural providers into Advanced Payment Models, payment calculations must be transparent and predictable. The MSSP does not appropriately account for the ongoing adjustments of the payment rates for CAHs, which account for about 1/3 of rural Medicare Spending. CMS also protects certain payments from the cost calculation, such as indirect medical education and disproportionate share

hospital payments, because these additional payments are supporting important programs for Medicare. The same considerations should be made for payments to rural hospitals, clinics and FQHCs, which are also important programs for Medicare.

Support the Rural ACO Improvement Act of 2015 to correctly attribute patients to the Nurse Practitioners and Physician's Assistants who are the primary care providers for many rural beneficiaries. The Rural ACO Improvement Act, recently introduced by Senators Cantwell and Thune, with a companion bill from Congressman Welch and Black, corrects an anomaly of the Affordable Care Act that does not recognize non-physician primary care providers for the majority of attribution under the MSSP. As a result, attribution in rural health systems served by Physicians and Advanced Practice Nurses and Physician's Assistants is generally 1/3 lower than attribution for Physician-only ACOs. Recent changes to the methodology in MSSP attribution will improve attribution somewhat, but still require that the patient see a Physician in the ACO at least once per year. Our beneficiaries are confused by requirements to see a Physician in addition to their designated non-physician primary care provider.

Support the REACH Act to preserve local access to emergency, short stay, skilled nursing, outpatient and primary care in communities that are too small to continue to support an acute care hospital. The REACH Act, recently introduced by Senator Grassley, provides an important alternative to the closure of rural hospitals that provide services for populations too small to support an Acute Care Hospital. We commend Senator Grassley and the National Rural Health Association for the development of this model.

We thank the Committee for its outstanding support of rural health and rural beneficiaries, and look forward to continued dialogue on how to deliver better care at a lower cost in rural America.

Sincerely,

Lynn Barr

Lynn Barr, MPH
Chief Transformation Officer
National Rural ACO
P.O. Box 1330
Nevada City, CA 95959
Telephone: 916.500.4777
FAX: 916.914.2092

ORGANIZATIONS REPRESENTED BY THIS LETTER

	FACILITY NAME	ADDRESS	CITY, STATE, ZIP
1	***Caverna Memorial Hospital***	1501 South Dixie Street	Horse Cave, KY 42127
2	***The James B. Haggin Memorial Hospital***	464 Linden Avenue	Harrodsburg, KY 40330
3	***Monroe County Medical Center***	529 Capp Harlan Road	Tompkinsville, KY 42167
4	***Breckinridge Health***	1011 Old Highway 60	Hardinsburg, KY 40143
5	***Livingston Hospital and Healthcare Services, Inc.***	131 Hospital Dr	Salem, KY 42078
6	***Ohio County Hospital***	1211 Old Main Street	Hartford, KY 42320
7	***Carroll County Memorial Hospital***	309 Eleventh Street	Carrollton, KY 41008
8	***Twin Lakes Regional Medical Center***	910 Wallace Ave.	Leitchfield, KY 42754
9	***Rhea Medical Center***	9400 Rhea County Hwy	Dayton, TN 37321
10	***Southeast Colorado Hospital District.***	373 E. Tenth Ave	Springfield, CO 81073
11	***Spanish Peaks Regional Health Center & Spanish Peaks Veterans Community Living Center***	23500 US Hwy. 160	Walsenburg, CO 81089
12	***Prowers Medical Center***	401 Kendall Drive	Lamar, CO 81062
13	***Yuma District Hospital & Clinics***	1000 West 8th Avenue	Yuma, CO 80759
14	***Mt. San Rafael Hospital***	410 Benedicta Avenue	Trinidad, CO 81082
15	***Arkansas Valley Regional Medical Center***	1100 Carson	La Junta, CO 81050
16	***Colorado West Healthcare System***	2021 North 12th Street	Grand Junction, CO 81501
17	***Colorado Canyons Hospital & Medical Center - Family Health West - Lower Valley Hospital Assoc.,***	300 W. Ottley	Fruita, CO 81521
18	***LeFlore County Hospital Authority dba Eastern Oklahoma Medical Center***	PO Box 1148	Poteau, OK 74953
19	***Wagoner Community Hospital***	1200 West Cherokee	Wagoner, OK 74467
20	***Wilson County Hospital dba Wilson Medical Center***	2600 Ottawa Road P.O. Box 360	Neodesha, KS 66757
21	***Belmond Community Hospital; dba Iowa Specialty Hospital - Belmond***	403 1st St. SE	Belmond, IA 50421
22	***Iowa Specialty Hospital - Clarion***	1316 S. Main St.	Clarion, IA 50525
23	***Sioux Center Health***	1101 9th St. SE	Sioux Center, IA 51250
24	***Cass County Health System***	1501 E 10th St.	Atlantic, IA 50022
25	***Virginia Gay Hospital***	502 N. 9th Ave.	Vinton, IA 52349
26	***Greater Regional Medical Center***	1700 West Townline Street	Creston, IA 50801
27	***Fort Madison Community Hospital***	5445 Avenue O	Fort Madison, IA 52627
28	***Fairfield Memorial Hospital***	303 N.W. 11th Street	Fairfield, IL 62837
29	***ProHealth, Inc. DBA Pekin Memorial Hospital***	600 S. 13th Street	Pekin, IL 61554
30	***St. Margaret's Hospital***	600 East First Street	Spring Valley, IL 61362
31	***Graham Health System***	210 West Walnut	Canton, IL 61520
32	***Morris Hospital & Healthcare Centers***	150 West High Street	Morris, IL 60450

ORGANIZATIONS REPRESENTED BY THIS LETTER

	FACILITY NAME	ADDRESS	CITY, STATE, ZIP
33	***Margaret Mary Health***	321 Mitchell Avenue	Batesville, IN 47006
34	***Henry County Memorial Hospital***	1000 N. 16th Street	New Castle, IN 47362
35	***Hancock Regional Hospital***	801 North State Street	Greenfield, IN 46140
36	***Hendricks County Hospital***	1000 East Main Street	Danville, IN 46122
37	***Johnson Memorial Hospital.***	1125 W Jefferson Street	Franklin, IN 46131
38	***Witham Memorial Hospital***	2605 N Lebanon St.	Lebanon, IN 46052
39	***Reid Hospital & Health Care Services, Inc.***	1100 Reid Parkway	Richmond, IN 47374
40	***Sullivan County Community Hospital***	P.O. Box 10 2200 North Section Street	Sullivan, IN 47882
41	***Jay County Hospital***	500 W Vitaw Street	Portland, IN 47371
42	***Perry County Memorial Hospital***	8885 SR237	Tell City, IN 47586
43	***Decatur County Memorial Hospital***	720 N. Lincoln St.	Greensburg, IN 47240
44	***King's Daughters Health***	PO Box 447	Madison, IN 47250
45	***Daviess Community Hospital.***	1314 E. Walnut Street	Washington, IN 47501
46	***Fayette Regional Health System***	1941 Virginia Street	Connersville, IN 47331
47	***Pulaski Memorial Hospital***	616 East 13th Street	Winamac, IN 46996
48	***Marlette Regional Hospital***	2770 Main Street	Marlette, MI 48453-0307
49	***McKenzie Health System***	120 Delaware Street	Sandusky, MI 49471
50	***Scheurer Hospital***	170 N. Caseville Road	Pigeon, MI 48755-9781
51	***Alcona Citizens for health, Inc.***	177 N. Barlow Rd.	Lincoln, MI 48742
52	***Cedar Hill Medical Dickinson County Healthcare System***	1721 S. Stephenson Ave.	Iron Mountain, MI 49801
53	***Hills & Dales General Hospital***	4675 Hill Street	Cass City, MI 48726
54	***Hayes Green Beach Memorial Hospital***	321 East Harris Street	Charlotte, MI 48813
55	***Helen Newberry Joy Hospital & Healthcare Center***	502 West Harrie Street	Newberry, MI 49868
56	***Schoolcraft Memorial Hospital***	7870 W. US Highway 2	Manistique, MI 49854
57	***Sheridan Community Hospital***	301 North Main Street	Sheridan, MI 48884
58	***Hillsdale Community Health Center***	168 S. Howell	Hillsdale, MI 49242
59	***Charlotte Family & Urgent Care Center***	616 Meijer Drive	Charlotte, MI 58813
60	***Community Health Center of Branch County***	274 E. Chicago Street	Coldwater, MI 49036
61	***Sturgis Hospital***	916 Myrtle Avenue	Sturgis, MI 49091
62	***South Haven Health System***	955 South Bailey Avenue	South Haven, MI 49090
63	***Allegan General Hospital***	555 Linn Street	Allegan, MI 49010
64	***Three Rivers Health***	701 South Health Parkway	Three Rivers, MI 49093
65	***Indian Stream Health Center***	141 Corliss Lane	Colebrook, NH 03576
66	***Cottage Hospital***	90 Swiftwater Road	Woodsville, NH 03785
67	***Weeks Medical Center***	173 Middle Street	Lancaster, NH 03584
68	***Ammonoosuc Community Health Services, Inc.***	25 Mount Eustis Road	Littleton, NH 03561
69	***Littleton Regional Healthcare***	600 Saint Johnsbury Road	Littleton, NH 03561
70	***Androscoggin Valley Hospital.***	59 Page Hill Rd	Berlin, NH 03570

ORGANIZATIONS REPRESENTED BY THIS LETTER

	FACILITY NAME	ADDRESS	CITY, STATE, ZIP
71	***Upper Connecticut Valley Hospital Association, Inc.***	181 Corliss Lane	Colebrook, NH 03576
72	***Monadnock Community Hospital***	452 Old Street Road	Peterborough, NH 03458
73	***Van Wert County Hospital***	1250 South Washington St.	Van Wert, OH 45891
74	***The Bellevue Hospital***	1400 West Main Street	Bellevue, OH 44811
75	***Knox Community Hospital***	1330 Coshocton Ave.	Mount Vernon, OH 43050
76	***Fisher Titus Medical Center***	272 Benedict Avenue	Norwalk. OH 44857
77	***Berger Health System***	600 North Pickaway Street	Circleville, OH 43113
78	***Davis Medical Center***	PO Box 1484	Elkins, WV 26241
79	***Broaddus Hospital***	#1 Healthcare Drive	Philippi, WV 26416
80	***Grant Memorial Hospital***	PO Box 1019	Petersburg, WV 26847
81	***Stonewall Jackson Memorial Hospital***	230 Hospital Plaza	Weston, WV 26452
82	***Perry County Memorial Hospital***	434 N. West Street	Perryville, MO 63775
83	***Nevada Regional medical Center***	800 S. Ash	Nevada, MO 64771
84	***Missouri Delta Medical Center***	1008 North Main	Sikeston, MO 63801
85	***Seminole Hospital District***	209 NW 8th Street	Seminole, TX 79360
86	***Cuero Community Hospital***	2550 N. Esplanade	Cuero, TX 77954
87	***Graham Hospital District***	1301 Montgomery Road	Graham, TX 76450
88	***Gonzales Healthcare Systems***	P.O. Box 587	Gonzales, TX 78629
89	***Hill Country Memorial***	1020 South State Highway 16	Fredericksburg, TX 78624
90	***El Campo Memorial Hospital***	303 Sandy Corner Road,	El Campo, TX 77437
91	***Brazosport Regional Physician Services Organization***	100 Medical Drive	Lake Jackson, TX 77566
92	***Chambers County Public Hospital District #1 d.b.a. Chambers Health***	P.O. Box 398	Anahuac, Texas 77514-0398
93	***Chambers County Public Hospital District #1 d.b.a. Chambers Health***	P.O. Box 398	Anahuac, Texas 77514-0398
94	***Coryell Memorial Healthcare System***	1507 W Main	Gatesville, TX
95	***Matagorda Regional Medical Center.***	104 7th St	Bay City, TX 77414
96	***Connally Memorial Medical Center***	499 10th St.	Floresville, TX 78114
97	***Northern Hospital of Surry County***	830 Rockford Street	Mount Airy, NC 27030
98	***Hugh Chatham Memorial Hospital***	180 Parkwood Drive	Elkin, NC 28621
99	***Edisto Regional Health Services Organization***	3000 St. Matthews Road	Orangeburg,SC 29118
100	***Miller County Hospital.***	209 N. Cuthbert St	Colquitt, GA 39837
101	***Chatuge Regional Hospital.***	110 S. Main St	Hiawassee, GA 30546
102	***Effingham Health System.***	459 Highway 119 S	Springfield, GA 31329
103	***Appling Healthcare System***	163 East Tollison Street	Baxley, GA 31513
104	***Northwest Medical Partners, P.A.***	280 N. Pointe Boulevard	Mount Airy, NC 27030
105	***Union General Hospital***	35 Hospital Rd	Blairsville, GA 30512
106	***North Mississippi Medical Clinics, Inc. (North Mississippi Medical Center-Hamilton)***	1150 S. Green St., Suite 1A	Tupelo, MS 38804
107	***North Mississippi Medical Clinics, Inc. (North Mississippi Medical Center-Eupora)***	1150 S. Green St., Suite 1A	Tupelo, MS 38804

ORGANIZATIONS REPRESENTED BY THIS LETTER

	FACILITY NAME	ADDRESS	CITY, STATE, ZIP
108	***North Mississippi Medical Clinics, Inc. (North Mississippi Medical Center-Pontotoc)***	1150 S. Green St., Suite 1A	Tupelo, MS 38804
109	***Anderson Regional Medical Center - South Campus***	1102 Constitution Ave.	Meridian, MS 39301
110	***King's Daughters Medical Center***	427 Highway 51N	Brookhaven, MS 39602
111	***North Mississippi Medical Clinics, Inc.***	1150 S. Green St., Suite 1A	Tupelo, MS 38804
112	***Hattiesburg Clinic***	415 South 28th Avenue	Hattiesburg, MS 39401
113	***Fishermen's Hospital, Inc.***	3301 Overseas Highway	Marathon, FL 33050
114	***Doctors Memorial Hospital***	2600 Hospital Drive	Bonifay, FL 32425
115	***Bailey Family Practices***	101 E. Wisconsin Ave	Bonifay, FL 32425
116	***Hendry Regional Medical Center***	524 W. Sagamore Avenue	Clewiston, FL 33440
117	***Northwest Florida Community Hospital***	1360 Brickyard Rd PO Box 889	Chipley, FL 32428
118	***Jackson Hospital***	4250 Hospital Drive	Marianna, FL 32446
119	***Medlink Management Services, Inc.***	850 East Main Street	Lake Butler, FL 32054
120	***Calhoun Liberty Hospital***	20370 NE Burns Avenue	Blountstown, FL 32424
121	***Memorial Medical Center***	216 Sunset Place	Neillsville, WI 54456
122	***Jersey Shore Hospital***	1020 Thompson Street	Jersey Shore, PA 17740
123	***Ridgecrest Regional Hospital***	1081 N. China Lake Blvd.	Ridgecrest, CA 93555
124	***Truckee Tahoe Medical Group***	10956 Donner Pass Rd. #110	Truckee, CA 96161
125	***Mammoth Hospital***	PO Box 660	Mammoth Lakes, CA 93546
126	***Barton Health***	2170 South Avenue	South Lake Tahoe, CA 96150
127	***Southern Inyo Healthcare District***	P.O. Box 1009	Lone Pine, CA
128	***Inland Behavioral and Health Services, Inc.***	1963 North E. Street	San Bernardino, CA 92405
129	***Roosevelt General Hospital***	42121 Hwy 70, PO Box 868	Portales, NM 88130
130	***Cibola General Hospital***	1016 E. Roosevelt Ave	Grants, NM 87020
131	***Artesia General Hospital***	702 N. 13th Street	Artesia, NM 88210
132	***Nor-Lea Hospital District***	1600 North Main	Lovington, NM 88260
133	***Rehoboth McKinley Christian Health Care Services***	1901 Red Rock Drive	Gallup, NM 87301
134	***Miners' Colfax Medical Center***	203 Hospital Drive	Raton, NM 87740
135	***Mason General Hospital & Family of Clinics***	PO Box 1668	Shelton, WA 98584
136	***Summit Pacific Medical Center***	600 E. Main Street	Elma, WA 98541
137	***Lower Umpqua Hospital District***	600 Ranch Road	Reedsport, OR 97467
138	***PeaceHealth Peace Harbor Hospital***	400 9th Street	Florence, OR 97439
139	***Cottage Grove Community Medical Center***	1515 Village Drive	Cottage Grove, OR 97424
140	***Newport Hospital & Health Services***	714 West Pine Street	Newport, WA 99156
141	***Clallam County Public Hospital District #1***	530 Bogachiel Way	Forks, WA 98331
142	***Klickitat Valley Health***	310 S. Roosevelt	Goldenvale, WA 98620

ORGANIZATIONS REPRESENTED BY THIS LETTER

	FACILITY NAME	ADDRESS	CITY, STATE, ZIP
143	***Coulee Medical Center***	411 Portways Road	Grand Coulee, WA 99133
144	***Tri-State Memorial Hospital & Medical Campus,***	1221 Highland Ave	Clarkston, WA 99403
145	***Jefferson Healthcare***	834 Sheridan	Port Townsend, WA 98368
146	***Ferry County Hospital District #1***	36 N. Klondike Road	Republic, WA 99166
147	***Columbia County Health System***	2012 S. 3rd Street	Dayton, WA 99328
148	***Sunnyside Community Hospital & Clinics***	P.O. Box 719	Sunnyside, WA 98944
149	***Central Montana Medical Center***	408 Wendell Avenue	Lewistown, MT 59457
150	***Sidney Health Center***	216 14th Avenue SW	Sidney, MT 59270
151	***St. Luke Community Hospital***	107 6th Ave SW	Ronan, MT 59864
152	***Public Hospital District for Beaverhead County dba Barrett Hospital and Health Care Organization***	600 MT Highway 91 South	Dillon, MT 59725
153	***Marcus Daly Memorial Hospital***	1200 Westwood Drive	Hamilton, MT 59840
154	***Clark Fork Valley Hospital & Family Medicine Network***	P.O. Box 768	Plains, MT 59859
155	***Community Hospital of Anaconda***	401 West Pennsylvania	Anaconda, MT 59711
156	***Steele Memorial Medical Center***	203 South Daisy Street	Salmon, ID 83467
157	***North Valley Hospital***	1600 Hospital Way	Whitefish, MT 59937
158	***Clearwater Valley Hospital.***	301 Cedar Street	Orofino, ID 83544
159	***St. Mary's Hospital***	701 Lewiston St. PO Box 137	Cottonwood, ID 83522
160	***Gritman Medical Center***	700 S. Main	Moscow, ID 83843
161	***Moscow Family Medicine***	623 South Main Street	Moscow, ID 83843
162	***West Park Hospital District***	707 Sheridan Avenue	Cody, WY 82414
163	***Memorial Hospital of Carbon County***	2221 West Elm St PO Box 460	Rawlins, WY 82301
164	***Lake Region Healthcare.***	712 S. Cascade Street	Fergus Falls, MN 56537
165	***Memorial Community Health Inc.***	1423 7th Street	Aurora, NE 68818
166	***Winona Health Services***	855 Mankato Ave	Winona, MN 55987
167	***Madison Lutheran Home***	900 2nd Avenue	Madison, MN 56256
168	***Heart of America Medical Center***	800 S. Main Avenue	Rugby, ND 58368
169	***Sakakawea Medical Center***	510 8th Ave NE	Hazen, ND 58545
170	***McKenzie County Healthcare Systems, Inc.***	516 North Main	Watford City, ND 58854
171	***Southwest Healthcare Services***	802 2nd Street NW	Bowman, ND 58623
172	***First Care Health Center***	115 Vivian Street PO Box I	Park River, ND 58270
173	***UND Center for Family Medicine***	701 East Rosser Avenue	Bismarck, ND 58501

National Rural Health Association, testimony

Contact: Maggie Elehwany
Vice President
Government Affairs and Policy
National Rural Health Association

Elehwany@nrharural.org
(202) 639-0550
1025 Vermont St. NW, Suite 1100
Washington, DC 20005

Testimony of the National Rural Health Association (NRHA)
Concerning Access to Rural Health Care and MedPAC's report
Submitted for the Record to the House Committee on Ways and Means Subcommittee on Health

The National Rural Health Association (NRHA) is pleased to provide the House Ways and Means Subcommittee on Health a statement regarding the significance of rural health care to patients and providers.

NRHA is a national nonprofit membership organization with a diverse collection of 21,000 individuals and organizations who share a common interest in rural health. The association's mission is to improve the health of rural Americans and to provide leadership on rural health issues through advocacy, communications, education and research.

Access to quality, affordable health care is essential for the 62 million Americans living in rural and remote communities. Rural Americans are more likely to be older, sicker and poorer then their urban counterparts. Specifically, they are more likely to suffer with a chronic disease that requires monitoring and follow up care, making convenient, local access to care necessary to ensuring patient compliance with the services that are necessary to reduce the overall cost of care and improve the patients' outcomes and quality of life. Yet, many rural Americans live in areas with limited health care resources, restricting their available options for care, including primary care.

NRHA strongly disagrees with the Medicare Payment Advisory Commission's (MedPAC) assumption that there is no difference in access between urban and rural beneficiaries and the findings that access to care for rural patients is no longer a concern. Access to health care is an increasing concern for rural beneficiaries, exacerbated by the increasing crisis of rural hospital closures. Access in rural America is impeded by not only geography, but also by decreasing reimbursements, physician shortages, and excessive regulatory burdens.

The Administration and Congress have agreed that access still remains a concern. Testimony from the Office of Rural Health Policy to the Senate Appropriations Committee in May 2015 stated, "Individuals in rural communities have to travel farther for regular check-ups and emergency services, which can significantly increase the cost of medical treatment and impact outcomes in emergencies when time is critical."

Rural Medicare beneficiaries face a number of challenges when trying to access health care close to home. Seventy-seven percent of rural counties in the U.S. are Primary Care Health Professional Shortage Areas while nine percent have no physicians at all. Rural seniors are forced to travel significant distances for care, especially specialty services. In an emergency, rural American travel twice as far as their urban counterparts to receive care. As a result, while 20 percent of Americans live in rural areas, 60 percent of trauma deaths occur in rural America.

Rural programs and designations, from the Physician Work Geographic Practice Cost Index to Critical Access Hospitals, are essential to increasing the capacity of the rural health care delivery system to ensure access for rural senior and ensure these rural safety net providers can fulfill that mission. NRHA urges the Committee to continue its strong support of these important programs.

Rural Payment Provider Policies

Congress has created several rural health payment provisions to improve access to care in rural America. While these programs have been largely successful in maintaining access, continuation of these payments and rural health extenders is crucial. To provide these rural providers with certainty and the ability to engage in longer term planning, NRHA has long sought legislation to make the rural extenders permanent. But even with the existing program, the problem of access still remains. Rural Healthy People 2010 highlighted access as the greatest challenge in rural health. Unfortunately, even with the existing rural health programs, it remains the number one problem in the updated Rural Health People 2020. More must be done to ensure rural Americans have access to the health care resources necessary to allow them to lead healthy lives.

Rural health care delivery is challenging. Workforce shortages, older and poorer patient populations, geographic barriers, low patient volumes and high uninsured and under-insured populations are just a few of the barriers. Rural physicians and hospitals work around many of these barriers to provide high quality personalized care to their communities. Congress has address some of the payment related barriers by creating specific payment structures for certain rural providers to better address the unique patient populations and structural challenges faced by these small rural practices.

Medicare and Medicaid – major components of rural health care – pay rural providers less than their urban counterparts. Medicare spends 2.5 percent less on rural beneficiaries than it does on urban beneficiaries. Critical Access Hospitals (CAHs) make up nearly 30 percent of acute care hospitals, but receive less than 5 percent of total Medicare payments to hospitals. Rural health care providers operate on very thin margins and many rural communities have severe medical workforce shortages. Yet, rural physicians, who put as much time, skill and intensity into their work as their urban counterparts, are reimbursed at lower rates.

Congressionally established rural payment programs for hospitals and providers are not ‘bonus’ or ‘special’ payments, but rather alternative, cost-effective and targeted payment formulas that maintain access to care for millions of rural patients and financial stability for thousands of rural providers across the country.

NRHA is concerned that MedPAC does not take into account temporary payments when looking into the financial stability of providers, including rural hospitals. The March MedPAC report indicates the 2013 overall Medicare margins for rural hospitals (excluding CAHs) was 0.2 percent. In discussing this margin, the report concedes this is largely a result of Health technology payments that are declining from 2013 to 2016, meaning these payments are not going to be a part of the margin for hospitals for very much longer. NRHA believes MedPAC should take into account the temporary, and targeted, nature of these payments in making

determinations on payment adequacy. These payments are targeted for the purchase of expensive health IT products that add substantial costs to a hospital and were never intended to be used to justify actual reimbursement costs calibrated to sufficient cover the cost of care and ensure the availability of future care.

Additionally MedPAC shows that rural hospital all-payer margins are substantially lower than for urban hospitals. Over 40 percent of rural hospitals are operating with negative margins. Yet, MedPAC does not seem to take into account the temporary nature of incentive payments, such as HIT, when considering important rural add on payments.

Without access to care in local communities, rural patients would be forced to travel further for more expensive care. Or worse, these rural Americans would forego essential care because they could not reach the necessary medical providers, resulting in poorer health, a lower quality of life, and more expensive care later. The existing rural payments help, but rural access remains a critical problem with potential life and death consequences for rural Americans.

Hospital Closure Crisis

Rural health care challenges are well known – from accessing health care services to recruiting and retaining health professionals. Rural communities depend on safety net providers such as Critical Access Hospitals, Community Health Centers, Rural Health Clinics and Federally Qualified Health Centers.

But these important rural access points are facing a closure crisis. Fifty-six rural hospitals have closed since 2010; 283 more are on the brink of closure. Since the start of 2013, more rural hospitals have closed than in the previous 10 years—combined. These closures are a part of a larger trend according to the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, and their numbers show the rate is escalating. Continued cuts in hospital reimbursements have taken their toll, forcing far too many closures and leaving many of our nation's most vulnerable populations without timely access to care.

The March 2015 MedPAC report stated that the rural hospitals were a proportionate share of the overall hospital closures at 44 percent. Unfortunately, in rural America these closures are a part of a larger trend according to the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, 56 rural hospitals have closed since 2010, and their numbers show the rate is escalating. Additionally, comparing rural and urban closure percentages fails misses the real problem of hospital closures. When a rural hospital closes, the additional distance to care is significantly greater than an urban closure. Additionally, the closure of a hospital often results in the loss of other health care in the community, increasing the distance to receiving non-hosptal based care.

An iVantage study shows at the financial situation of the remaining rural hospitals and found that an additional 283 rural hospitals are on the brink of closure. Before these closures, Research shows that a rural resident is already traveling twice as far to get to emergency care. According to the March 2015 report the closed hospitals are an average of 21 miles to the next nearest hospital, yet the report does not specifically address the issue of access to care in rural

America. Already, more than 40 percent of rural patients have to travel 20 or more miles to receive specialty care, compared to 3 percent of metropolitan patients. Rural hospitals provide excellent care to rural Americans, and without these rural hospitals, more patients lose access points to care. When a patient has a heart attack, 21 additional miles of travel makes a difference in patient outcomes. Without access to local emergency care, a patient is more likely to experience loss of function and future impairment, resulting in reduced quality of life and increased Medicare expenditures.

A rural hospital closing doesn't just hurt patients; it hurts the rural economy as well. In rural America, the hospital is often one of the largest employers in the community. Health care in rural areas can represent up to 20 percent of the community's employment and income. The average CAH creates 195 jobs and generates $8.4 million in payroll annually. If a rural provider is forced to close their door the community erodes. If we allow the 283 rural hospitals that are on the brink to close: 36,000 direct rural health care jobs will be lost; 50,000 rural community jobs will be lost; and rural economies would take a $10.6 billion loss. When a rural hospital closes, leaving a community without local access to health care, the community quickly begins to die.

Unfortunately, we have seen the impact of hospital closures before. From 1990 to 1999, 208 rural hospitals closed and rural Americans lost access to health care. These hospitals struggled to maintain financial stability under the urban-centric Medicare Prospective Payment System because of their small size and unpredictable patient mix. Congress enacted the Medicare Rural Hospital Flexibility Program as part of the Balance Budget Act (BBA) of 1997, creating the Critical Access Hospital (CAH) designation. This designation was designed to prevent hospital closures by allowing CMS payments to more accurately reflect the realities of providing care in rural America. The CAH payment structure allows for more flexible staffing options relative to community need, simplifying billing procedures and creating incentives to develop local integrated health delivery systems, including acute, primary, emergency and long-term care.

Congress created unique payment structures for certain rural providers to enable them to keep their doors open and to allow them to continue to serve their communities by providing access to high quality health care.

Rural Hospitals provide cost-effective primary care. It is 2.5 percent less expensive to provide identical Medicare services in a rural setting than in an urban or suburban setting. This focus on primary care, as opposed to specialty care, saves Medicare $1.5 billion per year. Quality performance measurements in rural areas are on par if not superior to urban facilities.

NRHA asks members of the Committee and MedPAC to consider the impact of access to care for rural Americans when necessary safety net providers close. NRHA is calling on members of Congress to stabilize the rural health closures.

Regulatory Relief Needed

NRHA calls on regulatory relief to help the Medicare beneficiaries in rural America. The elimination of the CAH 96 Hour Condition of Payment, the rebase of supervision requirements for outpatient therapy services at CAHs and rural PPS facilities, and modification to the 2-Midnight Rule and RAC audit and appeals process would help relieve burdens placed unfairly on these small, rural hospitals and providers.

NRHA calls for the elimination of the 96 hour Condition of Payment requirement that physicians at CAHs certify, at the time of admission that a Medicare patient will not be at the facility for more than 96 hours. From the creation of the CAH designation until late 2013 an annual average of 96 hour stays allowed CAHs flexibility within the regulatory framework set up for the designation. The new policy of strict enforcement of a per stay 96 hour cap creates unnecessary red-tape and barriers for CAHs throughout rural America; and eliminates important flexibility to allow general surgical services well suited for these high quality local providers.

The 96-hour rule is counter to the clear congressional intent to provide CAHs greater flexibility, evident in the 1999 modification of the 96 hour condition of participation from a hard 96 hour cap to a flexible annual average. The sudden imposition of the condition of payment is unnecessary and limits access to health care in rural areas and disallows rural providers to focus on caring for their patients. This regulation interferes with the best judgment of physicians and other health care providers, placing them in a position where high quality and qualified local providers cannot provide care for their patients. As a result, patients have had to seek care far from home. Additionally, since it is 2.5 percent less expensive to provide identical Medicare services in a rural setting than in an urban or suburban setting, such a transfer results in greater Medicare expenditures. Removing the 96-hour rule condition of payment would allow for rural patients to receive the care they need in their local communities.

The Solution is Legislative

Twenty percent of Americans live on the 90 percent of America that is rural. For these Americans local access to care is essential, but there are substantial barriers and challenges involved in providing this care.

The rural payment programs created by Congress address just some of these challenges and help 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 full-time 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 and transferring patients to more expensive urban providers. 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 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 towards bipartisan rural legislation to address issues in the long-term and provide rural providers with the certainty they need. We encourage the committee to look at the Save Rural Hospitals Act, introduced by Reps. Sam Graves (R-MO) and Dave Loebsack (D-IA) as a guide for addressing all these issues in the long-term.

The National Rural Health Association appreciates the opportunity to provide our recommendations to the Subcommittee. These programs are critical to the rural health delivery system and help maintain access to high quality care in rural communities. We greatly appreciate the support of the Subcommittee and look forward to working with Members of the Subcommittee to continue making these important investments in rural health.

John Kastanis, President and CEO Temple University Hospital, statement

Statement for the Record of

John Kastanis, President and C.E.O.

Temple University Hospital

House Committee on Ways & Means, Subcommittee on Health

Hearing on Hospital Payment Issues, Rural Health Issues,

and Beneficiary Access to Care

Wednesday, July 22nd, 2015

On behalf of Temple University Hospital (TUH), I appreciate this opportunity to provide testimony for the record in follow up to the Committee's hearing Medicare payment issues. My testimony pertains to the issue of Medicare DSH payments and the need to mitigate the scheduled reductions in these payments.

The Challenge in Serving High-Need Safety Net Populations on Limited Medicare Reimbursement

The cuts in Medicare DSH payments mandated by the Patient Protection and Affordable Care Act (PPACA) are highly problematic for an institution such as TUH that serves a very high percentage of patients who are low income, minority, afflicted by behavioral health issues, and dually eligible for Medicare and Medicaid. In addition, we have a payer mix heavily skewed toward public programs with very little commercial insurance to help absorb costs.

Specifically, about 84% of TUH inpatients are covered by government programs, including 33% by Medicare and 51% by Medicaid. Patients that are dually eligible for Medicare and Medicaid comprise 23% of our inpatients who are covered by Medicare according to most current CMS data, placing TUH as #1 among Pennsylvania academic medical centers, in the 95th percentile among all acute care hospitals nationwide. Furthermore, about 42% of our inpatients include a behavioral health diagnosis.

Extensive research correlates a patient profile such as ours with higher costs of care. Despite this, we serve this challenging population in a highly efficient manner -- our wage and case mix adjusted discharge costs are in the lowest quartile of all Academic Medical Center hospitals as is our ratio of Full Time Equivalents (FTE) per occupied bed.[1] Notwithstanding this efficient delivery system, Medicare reimbursements fall well below actual cost. In fiscal year 2013, our case mix adjusted average cost for Medicare Fee-For-Service inpatients was $12,022 but our case mix adjusted Medicare reimbursement for this population was $9,805 (*including* both DSH and DME), well short of cost (81.5%).

In sum, Temple University Hospital serves a high-risk, high-cost public payer population in an efficient manner and with virtually no ability to have costs absorbed by commercial payers. Our Medicare reimbursement – even before the imposition of PPACA DSH cuts – does not cover the cost of that care and we are simply not able to absorb additional Medicare cuts. We are certainly not the only safety net institution facing this type of challenge, but we are quite certainly the type of institution for which Medicare DSH payments were originally intended.

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[1] Association of American Medical Colleges (AAMC) quarterly Operations and Financial Performance data,

The Need to Mitigate Pending Reductions in Medicare DSH Payments

To date, the Centers for Medicare and Medicaid Services (CMS) have partially mitigated the impact of PPACA's Medicare DSH cuts in their regulatory implementation of the program – they have used their authority to employ "proxy" data that measures the sum of an institution's Inpatient Medicaid Days and Inpatient Medicare SSI days for purposes of allocating reductions to the 75% of prior Medicare DSH funding that is subject to cuts under PPACA. But as these cuts grow in size over the coming years, this ability of CMS to mitigate the impact for some providers will diminish. And they are in any event unlikely to permanently utilize the proxy data approach.

A basic problem with the Medicare DSH cuts mandated in PPACA is that they applied an analysis by the Medicare Payment Advisory Commission (MedPAC) in a "broad brush" manner. In 2007, MedPAC analyzed the overall relationship between the DSH formula and Medicare costs per case and concluded that -- looking at *all* Medicare DSH hospitals -- about three-quarters of the DSH payments were not "empirically justified" (that is, they could not be correlated to higher costs per case). Leaving aside questions regarding the veracity of MedPAC's analysis, this overall correlation did not consider the much higher correlation seen in studies focused on only large urban hospitals -- let alone urban hospitals such as TUH with disproportionately high-risk caseloads.

Highly impacted institutions such as TUH struggle to overcome negative Medicare margins related to an extraordinarily disproportionate share of diverse, low-income, medically complex patients with a high incidence of behavioral health problems that complicate underlying medical issues. Medicare DSH payments are crucial to our ability to mitigate inadequate reimbursements under the Medicare Inpatient Prospective Payment System. Given our very low share of patients covered by commercial insurers, we are not able to shift costs to the private marketplace. Thus any additional cuts to Medicare DSH will challenge our ability to care for these unique patient populations and ultimately our ability to serve as a major point of access for Pennsylvania's most vulnerable citizens. We simply cannot absorb additional cuts to the Medicare DSH program and urge Congress to place a moratorium on these slated reductions.

We appreciate your consideration of these views.

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