Statement for the Record
Federation of American Hospitals

U.S. House of Representatives
Committee on Energy & Commerce
Subcommittee on Health

Hearing On "The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?"

Thursday, January 9, 2014

2123 Rayburn House Office Building

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

First and foremost, the FAH remains deeply concerned with the problems plaguing the current sustainable growth rate (SGR) formula and appreciates the Committee's efforts in providing a long-term resolution to the fundamental SGR flaw. In order to serve our patients' needs, America's hospitals rely on the quality and professionalism of their medical staffs. One of the greatest threats to our partnership with physicians is the lack of fair and predictable Medicare payment.

Furthermore, the FAH appreciates the Committee's interest in the impact of extenders policies on patients and providers alike. With twenty percent of America's population residing in rural America, rural hospitals are the health and economic backbone for many communities across America, delivering vital health care to millions of Americans. These facilities are often the sole source of comprehensive health care where they are located, and are typically the largest employer, and economic engine, in the communities they serve.

As Members of the Committee know all too well, hospitals have borne the brunt of mounting payment cuts in recent years – $113 billion having been imposed in the last three years alone, with the sequester accounting for nearly half of that amount. In total, hospitals must now absorb well over $400 billion in cuts in Medicare and Medicaid through 2023. In fact, rather than providing relief to the arbitrary Medicare sequester cuts, Congress in the budget agreement chose not only to maintain the level of the current sequester cuts to hospitals, but to extend these cuts an additional two years beyond the orginial timeframe. Such actions are never without consequences and will threaten jobs, patient access to care and hospital closures in rural regions.

Especially in this current economic environment, rural hospitals face a wide array of financial difficulties and operational challenges which imperil their ability to continue to serve these areas in the manner that rural citizens expect and deserve. In many ways, they are the frontline for the many cuts imposed on hospitals in recent years, chief among them the steady erosion of public funding under Medicare and Medicaid. Extending targeted payment policies that are set to expire at the end of March is critically important to bolster their fragile finances and help preserve these hospitals so they can continue to meet their mission.

The rural population served by community hospitals is typically older and poorer, which means that rural hospitals are forced to rely to a greater extent on Medicare and Medicaid funding, and are, therefore, especially vulnerable to cuts to these crucial sources of payment. These payment pressures, combined with the challenges of chronic workforce shortages, relentless regulatory burdens that increase in size and scope, limited access to capital, and the difficulty of a small rural hospital to generate economies of scale, further threaten an already vulnerable, yet vital community asset.

While we welcome the Subcommittee's examination of certain expiring policies, **we strongly urge the extension of the Low-Volume Hospital Payment Adjustment (LVH) and the Medicare Dependent Hospital program (MDH)** which provide vital support for rural hospitals that treat a relatively low volume of patients and a disproportionately high percentage of Medicare beneficiaries.

- **Low-Volume Hospital Payment Adjustment**

  This provision recognizes the fact that rural facilities, which are typically small and more isolated, are handicapped in their ability to drive lower unit costs through greater economies of scale. This sliding-scale payment adjustment helps compensate for this competitive disadvantage. It is particularly important because Medicare payments fall so far below the cost of care, and because these small rural hospitals have virtually no other revenue recourse to defray this substantial payment shortfall**.**

- **Medicare Dependent Hospital Program**

  As noted earlier, rural hospitals provide health care to communities that are typically older. This provision is designed to provide an additional measure of protection for smaller rural hospitals serving a disproportionate Medicare caseload – greater than 60 percent. Congress since 1987 has provided a modest supplemental payment to help ensure the survival of these hospitals and access to hospital care for seniors in rural communities. We urge Congress to continue this program and reassure seniors that the hospitals they depend on for care will be there when they need them.

The FAH is pleased to support legislation to extend the vital LVH and MDH programs. The Rural Hospital Access Act of 2013, H.R. 1787, was introduced by Representatives Tom Reed (R-NY) and Peter Welch (D-VT) and has the support of several Members of the Energy and Commerce Committee. In addition, S. 842 was introduced in the Senate by Senators Charles Schumer (D-NY) and Chuck Grassley (R-IA). Senators Schumer and Grassley were

also successful with an amendment in the Senate Finance Committee to their respective SGR legislation to permanently extend these two programs. The amendment passed by voice vote. The FAH remains hopeful that this Senate provision will be included in any final SGR package.

National Quality Forum (NQF)

The FAH strongly supports effective quality measurement based on standardized metrics that are scientifically sound and useable for public reporting and accountability. Essential to this goal is adequate, predictable and sustainable funding for measure development, multi-stakeholder review of quality measures for scientific soundness and multi-stakeholder assessment of quality measures for use in specific payment programs prior to rule-making. The FAH believes it to be critical that the development of any new streamlined value-based payment program, whether a Value-Based Performance (VBP) payment program or other quality program, recognize the critical role of the National Quality Forum (NQF) and the Measure Applications Partnership (MAP) convened by the NQF. These infrastructures have been instrumental in aligning public and private quality programs, streamlining measures, and providing perspective on whether measures are appropriate for specific federal quality programs and meaningful for patients, payers, providers and the private sector.

The work of the NQF and the MAP is a proven process for engaging strong multi-stakeholder efforts and consensus building, permitting a wide vetting of measures by multiple stakeholders based on criteria that establish validity, reliability, solid evidentiary base, and usability. Without these proven processes, we risk returning to fragmented past practices that had less consensus and alignment among quality programs in both the public and private sectors. The FAH strongly supports sustained, predictable funding for support of these programs and encourages the committee to include funding for these programs in the extender package.

Conclusion

Just this week, CMS reported that 2012 annual health care spending, including Medicare, is experiencing a significant slowdown. It is especially noteworthy that the Medicare slowdown occurred despite a 4.1 percent jump in enrollment in 2012. This news from CMS was the latest in a growing set of evidence from the federal government as well as academic researchers documenting a historic national spending slowdown with signs that this fortuitous cycle is likely to continue.

Experts attribute the spending slowdown to economic conditions and increasingly recognize structural factors as a root cause of the trend. These structural changes include cultural changes in the delivery of health care, innovative models of integrated care, and the adoption of technological advances such as interoperable electronic health records.

Slowing Medicare spending translates into ***savings*** – for the Medicare program and, in turn, federal deficit reduction. The June 2013 Dobson/Devanzo study commissioned by the FAH projected an additional $1 trillion in deficit reduction over the next 10 years if trends continue.

The goal of bending the cost curve is clearly under way, but the fiscal pressures on America's hospitals continue. At the FAH, our members are committed to providing essential health care services, as well as implementing structural changes that will sustain and strengthen the spending slowdown. Such improvements to the delivery of care must not be disrupted by the imposition of additional cuts to hospitals. As rural hospitals struggle simply to keep the doors open, to maintain services and prevent layoffs, the LVH and MDH programs have succeeded in providing the critical rural safety net hospitals need to continue to meet their community mission.

The FAH encourages the Members of the Subcommittee to continue their support for these payment policy lifelines to rural hospitals, as well as to recognize the importance of the NQF as we all work toward quality health care. We always stand ready to work with Congress to ensure continued access to quality health care for seniors.