



Charles N. Kahn III
President and CEO

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Dear Conferee:

The Federation of American Hospitals (FAH), representing America's investor-owned hospitals and managed health systems, strongly supports fixing Medicare's flawed physician payment system – a permanent solution is long overdue. However, we vigorously oppose cutting already inadequate Medicare and Medicaid payments for hospital services in order to finance this fix. Instead, we strongly encourage you to look at other sources of savings to cover the entire cost of a physician payment fix. These include medical malpractice reform – which according to the Congressional Budget Office (CBO) could generate well over \$50 billion in savings – and excess Overseas Contingency Operations (OCO) funding.

America's hospitals rely on the quality, accessibility, and professionalism of their medical staffs. Stable and adequate Medicare payment, for both physicians and hospitals, is essential to sustain this partnership and our shared goals of broad access to high quality care. This is why it is counterintuitive to reduce Medicare or Medicaid payments to hospitals, which already fall far below the cost of care, to offset the costs of preventing a Medicare payment cliff for physicians. Robbing hospital Peter to pay physician Paul is bad public policy, especially as hospitals come to grips with the cumulative impact of nearly \$200 billion in recent Federal cuts, including the Budget Control Act's two percent sequester. Hospitals also face constant state Medicaid cuts.

As you know, hospitals are economic engines and leading sources of jobs, and job growth, in virtually every community across the country. And yet the more than \$40 billion in hospital cuts from the sequestration alone could translate into nearly 200,000 total job losses. The prospect of another nearly \$20 billion in Medicare and Federal Medicaid cuts imbedded in the House-passed *Middle Class Tax Relief and Job Creation Act of 2011* (H.R. 3630), through policies that have not benefitted from transparent committee hearings or regular order, could lead to approximately 80,000 additional job losses, and increase the likelihood of fewer nurses, longer waits for emergency care and decreased access to new treatments.

The FAH respectfully urges the conference committee to reject the following sections in H.R. 3630:

Medicare Bad Debt – Section 2224

The FAH strongly opposes Section 2224 in the House-passed H.R. 3630, which cuts \$10.6 billion in Medicare payments that are made on behalf of seniors unable to satisfy their cost-sharing obligations (often referred to as “bad debt payments”). The purpose of these payments is to reimburse the costs of care that seniors receive, but only when they cannot meet their cost-sharing obligations. As you can well imagine, this is happening more frequently as seniors struggle with and fall victim to our faltering economy.

Medicare always has recognized these costs. Since the inception of the hospital prospective payment system, however, HHS elected to pay for these costs separately, outside the base bundled payment. So while they may appear as a stand-alone payment, they are no less a core hospital payment element than the adjusted base payment with which they are combined to constitute “payment in full.” Cutting these payments is tantamount to an across-the-board reduction that hurts all community hospitals – rural and urban, teaching and non-teaching alike – and the seniors they serve.

It also is important to note that an increasing share of these Medicare payments – now more than half – is attributable to Medicaid-enrolled low-income seniors in states with payment policies that, in effect, ignore all or a substantial portion of their cost-sharing obligations. Further, the Balanced Budget Act of 1997 put into statute policy that prohibits hospitals from collecting cost-sharing from this dual-eligible population. This puts hospitals in an untenable position with no other recourse.

It is critical that the Medicare program maintains its commitment to seniors and the hospitals that serve them.

Hospital Outpatient Payments for Evaluation & Management Services - Section 2223

Section 2223 would cut \$6.8 billion in Medicare outpatient hospital primary care payments from a system, according to the Medicare Payment Advisory Commission (MedPAC), that already pays hospitals some 10 percent below the cost of care. This policy is misguided, and ignores the important, fundamental difference in care delivered in hospital outpatient departments (HOPDs) and physician offices.

HOPDs treat higher-severity patients, undergo more complex procedures, and have more comorbidities and complications compared to patients treated in physician offices. This coincides with the broader community public health mission of an HOPD and the necessarily higher cost structures associated, among other responsibilities and mandates, with 24/7 emergency stand-by capacity and rigorous regulatory requirements unique to hospitals, including strict licensing and accreditation rules.

HOPDs provide primary care that is essential to secure the safety net for a variety of vulnerable populations, most notably low-income, inner-city patients as well as seniors in rural communities, where the population typically is older. Rural hospitals, particularly outpatient departments, also often serve as their communities' chief source of primary care. Reducing primary care visit payments as H.R. 3630 proposes clearly will weaken the safety net and jeopardize access to this vital care.

At a minimum, if Congress insists on moving forward with these unwise cuts to primary care payments, the savings must be budget neutral and restored to the chronically underfunded Medicare hospital outpatient payment system.

Medicaid Disproportionate Share Hospital Payments – Section 2225

In addition, the bill would cut \$4.1 billion in Medicaid DSH payments that are intended to support hospitals that serve a disproportionate share of Medicaid and uninsured patients. This policy prematurely extends an ACA provision that shrinks Medicaid DSH based on assumptions that increased coverage will significantly reduce the burden of uncompensated care costs borne by hospitals serving low-income populations. Further cuts to Medicaid DSH in advance of the 2014 coverage expansions is inappropriate, both because the coverage expansion has yet to occur and because it fails to acknowledge that hospitals will continue to face significant uncompensated care costs after 2014 due to their commitment to serving Medicaid and uninsured patients.

Critical Rural Extenders

The FAH urges the conference committee to build on the two month agreement in the “Temporary Payroll Tax Cut Continuation Act of 2011” and include critically important hospital rural payment extenders, below, in the final package. The FAH also believes it is important for the Medicare rural extenders to be tied to the same length of time as the SGR fix in order for Congress to appropriately address the needs of rural America.

- **Low-Volume Hospital Payment Adjustment**
- **Section 508 Wage Index Reclassification (Section 302, Final Agreement)**
- **Outpatient Hold Harmless for Small Rural Hospitals (Section 308, Final Agreement)**
- **Medicare Dependent Hospital Program**
- **Physician Pathology Services (Section 305, Final Agreement)**

Rural hospitals are the health and economic backbone for communities across America, delivering vital health care to millions of Americans. They often are the sole source of comprehensive health care where they are located, and typically are the largest employment and economic engine in the communities they serve. This is why the FAH strongly urges the conferees to include these critically important rural hospital Medicare payment extenders in the final package.

Further, while the FAH supports an extension of the therapy cap exception process, we strongly oppose the House-passed Section 2203, which generates additional savings by changing payment policy for therapy services delivered in hospital outpatient departments.

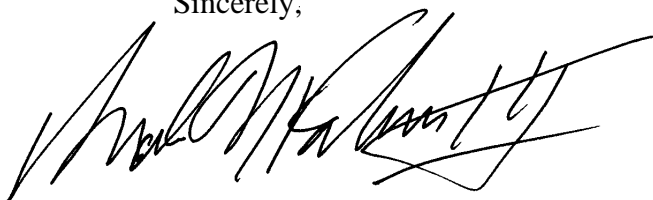
Self-Referral to Physician-Owned Hospitals – Section 2213

The FAH strongly opposes any weakening of the restrictions on self-referral to physician-owned hospitals and urges the conferees to reject the House-passed provision (Section 2213), which would represent a major step backwards for consumers and taxpayers. Current law represents an appropriate balancing that protects current physician ownership of existing hospital arrangements, and even permits growth where warranted, while protecting consumers and taxpayers against the well-documented dangers from the conflict of interest inherent in self-referral arrangements.

Congress has studied self-referral to physician-owned hospitals for well over a decade, and it has been thoroughly vetted and subjected to numerous hearings and independent studies. According to the CBO, MedPAC, and independent researchers, self-referral results in increased utilization of services and higher costs for the Medicare program. Full-service community hospitals embrace fair competition where facilities compete over quality, price and patient satisfaction. However, we are strongly opposed to self-referral, which skews the marketplace in favor of physician owners who self-refer the healthiest and wealthiest patients to their own facilities.

Thank you for your leadership and efforts to address these important health care issues, and for your attention to our concerns. It is our hope that we can continue to work together to meet the challenge of ensuring adequate payments for physicians and to strengthen, not weaken, the ability of hospitals to sustain America's fiscal and public health. In our view, these goals are mutually supportive, not mutually exclusive.

Sincerely,

A handwritten signature in black ink, appearing to be "William W. Bush" or similar, written in a cursive style.