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**AzHHA Headquarters
The Churchill Embassy Row
1914 Connecticut Avenue, NW
Washington, DC 20009
Telephone: (202) 797-2000
Fax: (202) 328-1984**



Arizona Hospital and Healthcare Association

List of Participants

Arizona Hospital and Healthcare Association

Greg Vigdor, President and CEO

Barb Fanning, Director, Government Affairs

Jim Haynes, Senior Vice President/COO

Debbie Johnston, Senior Vice President, Policy Development

Melody Regan, Manager, Member Services & Constituency Groups

IASIS Healthcare

David G. Covert, CPA, AZ/NV Market COO

Legacy Foundation of Southeast Arizona

Lanny A. Kope, EdD, Chair, Board of Trustees

Maricopa Integrated Health System

Steve Purves, FACHE, President and CEO

Michael Fronske, Director, Legislative and Governmental Affairs

Susan Gerard, Board Member

Northern Arizona Healthcare

Bill Bradel, FACHE, President and CEO

PHI Air Medical

Rachel Alvarez, Regional Director

Candace Reisinger, Operations Manager

Sierra Vista Regional Health Center

Elizabeth Patten, Trustee

Summit Healthcare

Ron McArthur, FACHE, CEO

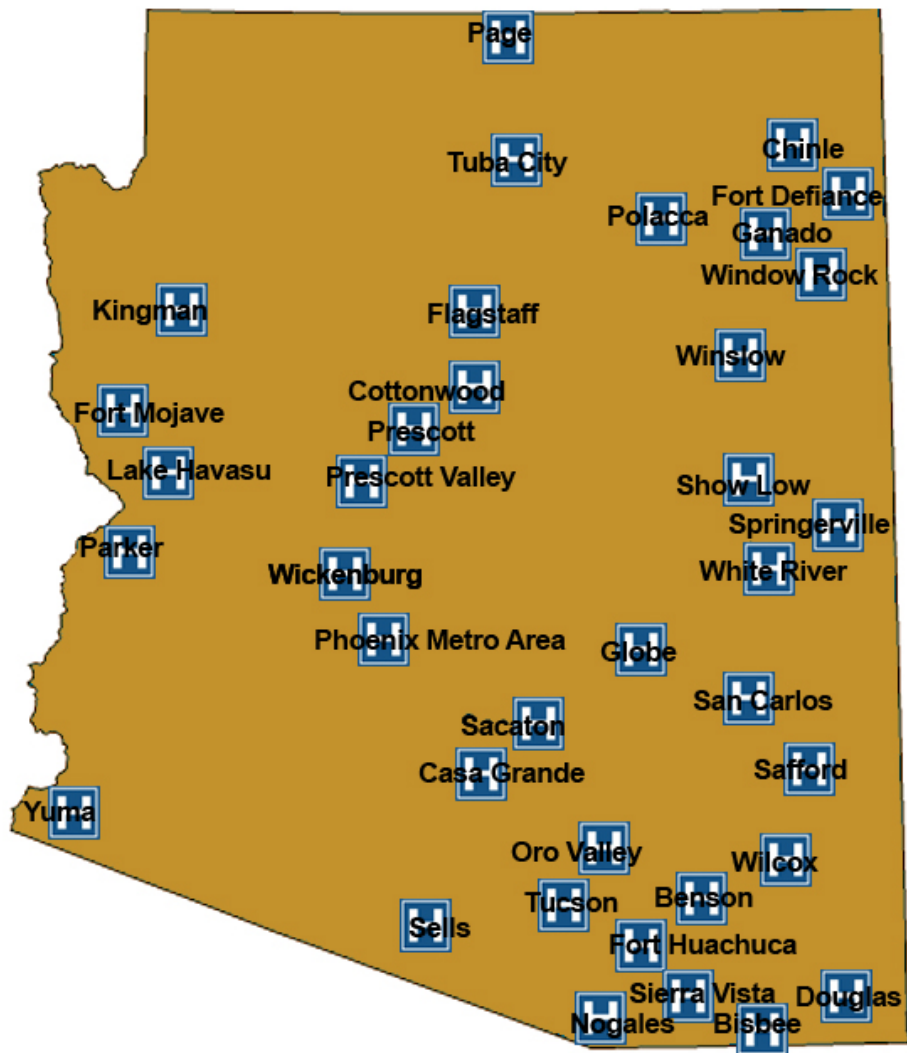
TMC HealthCare

Judy Rich, RN, President and CEO

Julia Strange, Vice President, Community Benefit



MAP OF ARIZONA HOSPITALS



Federal Advocacy Agenda

Arizona Hospital and Healthcare Association

April
2014

REJECT CUTS THAT THREATEN ACCESS TO CARE

Over the past few years, lawmakers have repeatedly turned to cutting Medicare provider payments to address budget shortfalls and/or offset the costs of maintaining existing programs or implementing new programs, including the expansion of insurance coverage provided by the *Affordable Care Act (ACA)*. In fact, Medicare payments to Arizona hospitals have been cut by nearly \$3.7 billion over 10 years to address these issues.

As Congress looks ahead for ways to further reduce federal spending and offset costs associated with fixing other programs, including a permanent solution to the sustainable growth rate, Medicare and Medicaid funding for hospitals will continue to be targeted. This prospect is particularly troubling in light of the progress that healthcare providers have made to constrain costs, the pressure they face to transform care delivery in an ever-changing regulatory environment, and the uncertainty surrounding implementation of the *ACA*.

AzHHA urges Arizona's congressional delegation to reject cuts to Medicare and Medicaid hospital payments as an offset for funding other federal programs, and to oppose the continuation of cuts contained in the *ACA* without the accompanying full implementation of the expanded coverage promised by the *Act*. AzHHA further urges Arizona's congressional delegation to reject poorly designed approaches to achieving Medicare savings through arbitrary provider cuts. Instead, we ask our delegation to support the development of more rational long-term payment methodologies that incentivize quality, promote better health outcomes, and improve efficiency, such as value-based purchasing.

PROVIDE RELIEF FROM EXCESSIVE FEDERAL REGULATIONS

Hospitals face huge challenges this year managing an enormous number of new regulatory hurdles and operational changes, including:

- Navigating thousands of pages of new and often confusing regulatory policies, including the two-midnight rule.
- Transitioning to new payment and delivery system models, including new penalty programs associated with hospital-acquired conditions and readmissions.
- Helping patients to understand the opportunities and risks, and keeping up with the changes, inherent in the new insurance marketplaces.
- Implementing complex and expensive electronic health record systems that must integrate information from many different sources.
- Coping with the excessive administrative burden and legal costs that result from improperly incentivized recovery audit contractors.

These regulatory and operational challenges place enormous burden on hospital leaders and their staff, taking resources away from where they should be—direct patient care. **As such, we urge Arizona’s congressional delegation to provide relief from excessive and harmful regulatory burdens by supporting the *Medicare Audit Improvement Act*, the *Two-Midnight Rule Delay Act/Two-Midnight Coordination and Improvement Act*, and the *Establishing Beneficiary Equity in the Hospital Readmissions Program Act*.**

PROTECT SMALL AND CRITICAL ACCESS HOSPITAL PAYMENTS

Rural hospitals, due to their small size, modest financial portfolio, and higher percentage of elderly and low-income patients, are particularly vulnerable to the financial risks associated with the Medicare prospective payment system. Recognizing this, Congress has established policies to protect and stabilize access-to-care for Medicare beneficiaries living in rural areas, including:

- The critical access hospital (CAH) program, under which Medicare pays qualifying small rural hospitals on a reasonable cost basis;
- The sole community hospital (SCH) program, under which qualifying hospitals are eligible for enhanced reimbursement; and
- The Low-Volume Adjustment, which makes supplemental payments to small, isolated hospitals with a low number of Medicare discharges.

Concerned that many CAHs do not meet existing qualifying criteria due to the existing necessary provider (NP) grandfather clause, Congress and the Administration have called for changes to the CAH program. These changes include reducing CAH payments and changing the mileage requirements between CAHs and other hospitals. AzHHA acknowledges that NP status may have been previously abused in some areas of the country, which is why Congress placed a moratorium on new NP designations in 2006. While no Arizona hospital qualifies for CAH status under this designation, they are nonetheless vulnerable to mileage and other changes that have been proposed for the CAH program.

Unlike many states, a significant proportion of Arizona CAHs are operated by IHS and tribal organizations. Some of these facilities are located in proximity to other CAHs or small rural hospitals operating in neighboring areas. The facilities serve their individual communities, but also collaborate and support one another as needed. Both are necessary to support the healthcare needs of rural Arizonans. **Should Congress move to change CAH mileage requirements, we urge Arizona’s congressional delegation to exclude from the mileage calculation, distances to hospitals serving unique populations (e.g., IHS or veterans’ hospitals) and those providing unique services (e.g., rehabilitation or psychiatric hospitals).**

AzHHA also urges Arizona’s delegation to support a permanent extension of the low-volume adjustment and improvements to the CAH program found in the *Critical Access Hospital Relief Act* and the *Protecting Access to Rural Therapy Services Act*, and to oppose any further reductions to CAH payments.

AzHHA's Position Paper on Medicare Cuts

Enough is Enough: Medicare Cuts Threaten Access to Care

The Issue

Over the past few years, lawmakers have repeatedly turned to cutting Medicare payments to providers to address budget shortfalls and/or offset the costs associated with implementing new programs, including the expansion of insurance coverage provided by the *Affordable Care Act (ACA)*. **In fact, Medicare payments to Arizona hospitals have been cut by nearly \$3.7 billion over 10 years to address these issues.** As Congress looks for ways to further reduce federal spending, address the debt ceiling, and offset costs associated with fixing the sustainable growth rate, Medicare payments to hospitals remain vulnerable. This prospect is particularly troubling in light of the uncertainty surrounding implementation of the *ACA*, including (1) the delay in employer penalties; (2) uneven Medicaid expansion due to both the U.S. Supreme Court decision that makes expansion voluntary and the future vulnerability of provider assessments, which are being scrutinized by Congress and the Administration; and (3) the narrow network designs that qualified health plans are adopting. Cuts are especially unfair in low-cost states like Arizona, which has the fourth lowest hospital expenditures per capita.¹

AzHHA's Position

AzHHA strongly opposes additional Medicare payment cuts and the continuation of cuts contained in the *ACA* without the accompanying full implementation of the expanded coverage promised by the *Act*. AzHHA also opposes poorly designed approaches to achieving Medicare savings through arbitrary provider cuts. Instead, we support the development of more rational long-term payment methodologies that reward quality and promote better health outcomes, such as value-based purchasing and accountable care models.

¹ Centers for Medicare & Medicaid Services (2011). *Health Expenditures by State of Residence*. Retrieved (December 2011) at <http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip>.

Background

Since 2010, Congress and the Centers for Medicare & Medicaid Services (CMS) have enacted a series of Medicare payment cuts for hospital services in their effort to address the federal deficit and offset other program costs, including the cost of expanding insurance coverage under the ACA. These cuts include:

- Various update factors, disproportionate share hospital (DSH) and quality-based payment cuts contained in the *ACA*;
- Sequestered cuts contained in the *Budget Control Act (BCA) of 2011*;
- Cuts to Medicare bad debt reimbursement contained in the *Middle Class Tax Relief and Job Creation Act of 2012*;
- An inpatient coding cut and outpatient payment cut for stereotactic radiosurgery services contained in the *American Taxpayer Relief Act (ATRA) of 2012*; and
- A separate permanent coding reduction implemented by CMS in 2013.

These cuts will cost Arizona hospitals \$3.7 billion in lost revenue over the next 10 years—approximately **11.2 percent of our hospitals' total Medicare fee-for-service revenue**. The chart below provides a breakdown of the existing cuts.

Existing Legislative Medicare Cuts¹

ACA Cuts (all provider settings)	(\$2,626,340,400)
Sequestration Cuts (all provider settings)*	(\$527,925,300)
Bad Debt Payment Cuts (all provider settings)	(\$11,131,300)
Coding Adjustment Cuts (inpatient hospital) and Radiosurgery Payment Cut (outpatient hospital)	(\$188,543,600)

Existing Regulatory Medicare Cuts²

Coding Adjustment Cuts (inpatient/home health)	(\$344,796,100)
Total Impact of Existing Cuts	(\$3,698,736,700)

* The sequestration cuts listed here do not include the \$132 million 10-year cost of extending those cuts into 2022 and 2023, as enacted under the Bipartisan Budget Act of 2013.

As Congress continues to deliberate ways to address the debt ceiling, offset the cost of fixing the physician payment formula, and further reduce federal spending, payments for hospital services remain vulnerable. Some of the cuts that have been discussed by Congress and the Administration include:

- Reducing outpatient payments to hospitals for evaluation and management (E/M) services as well as several other ambulatory payment classifications;
- Reducing critical access hospital (CAH) payments by 1 percent and eliminating the sole community hospital (SCH) program;
- Reducing direct and indirect graduate medical education (IME and GME) payments;
- Further reducing bad debt payments;
- Cuts to post-acute care providers, including inpatient rehabilitation facilities and long-term acute care hospitals; and
- Lowering the cap on Medicaid provider payments, a payment mechanism that Arizona has recently authorized to fund restoration of the Prop. 204 program and further expand Medicaid.

If enacted, these cuts would impact Arizona hospitals by more than \$1 billion over the next 10 years³:

Outpatient E/M Cuts (outpatient hospital)	(\$102,861,200)
Indirect Medical Education Cuts (inpatient hospital)	(\$428,936,700)
Direct Medical Education Cuts (inpatient hospital)	(\$76,304,300)
Bad Debt Payment Cuts (all provider settings)	(\$111,552,300)
SCH Program Elimination (inpatient hospital)	(\$360,262,700)
CAH Payment Cuts (inpatient/outpatient hospital)	(\$6,219,700)
<i>Total Impact of Cuts Under Consideration</i>	<i>(\$1,086,136,900)</i>

Analysis

Hospitals face many challenges in ensuring their patients have timely access to essential medical services. These include:

- Attracting, educating and retaining a high-quality workforce;
- Managing the high cost of technology, equipment, and pharmaceuticals;
- Coping with underpayments from government programs, such as Medicare and Medicaid;
- Providing care for the uninsured and those with multiple chronic diseases; and
- Complying with increasing regulatory and payer requirements.

Despite these challenges, hospitals have pushed forward to improve quality, reduce the cost of care, and proactively redesign the delivery system with an eye to achieving advancements in health outcomes and system efficiencies. These efforts are paying off.

According to the Altarum Institute, healthcare spending has grown at an average annual rate of 3.8 percent since 2010. This is the lowest rate on record for any four-year period and is less than half the annual growth rate of 9.3 percent since tracking began in 1960. Low growth in hospital prices is helping to fuel this trend. For 2013, hospital prices rose just 2 percent*. The news for Arizona consumers is particularly compelling. Based on CMS data compiled by the Kaiser Family Foundation, Arizona hospital expenditures per capita rank fourth lowest in the nation.

Hospitals have been able to achieve efficiencies through streamlining diagnostic tests and improving quality, redirecting non-emergency patients to community-based providers, improving case management to reduce readmissions, and enhancing supply side management. Even more savings can be achieved in the future as the system migrates further to value-based purchasing and population health management models.

But the journey to the future is fraught with uncertainties. The ACA's promise of expanded coverage is yet to be determined. The Administration has delayed, for example, the imposition of the employer penalties, and the U.S. Supreme Court has resolved that Medicaid expansion is voluntary. In Arizona, opponents of Medicaid expansion are challenging the enabling legislation. In addition, many of the qualified health plans operating on the Marketplace are shifting financial risk to consumers and providers through the use of high-deductible plans and narrow networks. Within this uncertain environment, Congress will be considering further cuts to hospital reimbursement.

Our Position

Arizona hospitals stand ready to provide care 24 hours a day, 7 days a week, ensuring patients have access to the critical medical services they expect. While hospitals will never compromise on quality, the constant ratcheting of funding for hospital services will impact patients' ability to receive the right care at the right time. Cuts will undoubtedly result in longer wait times, fewer doctors and other caregivers, and diminished access to the latest technology and treatments.

(*See attached AHA infographic.)

AzHHA urges Arizona's congressional delegation and federal officials to resist arbitrary cuts to provider payments and focus on real reforms that improve efficiency, reward quality, and target more appropriate utilization of healthcare services.

Medicare and Medicaid reforms should be based on sound public policy and a vision of transforming care that will reduce costs, increase quality and improve health outcomes of public program beneficiaries as well as the population at large. The focus should not be on arbitrary cuts that can expeditiously generate the most revenue savings. Payment reforms should target healthcare cost-drivers, but reforms should do so in a manner that does not inadvertently shift costs elsewhere in the system.

With this in mind, AzHHA opposes specious cuts to provider payments, including those that target outpatient evaluation and management services, Medicare bad debt and unsupported coding offsets. Instead, we support real reforms that improve efficiency, reward quality, and target more appropriate utilization of healthcare services, including:

- **Tying payment to performance through value-based purchasing;**
- **Implementing delivery and payment system reforms that align provider incentives to improve care coordination and quality through accountable care organizations, bundled payments, population health management, and state Medicaid demonstrations;**
- **Addressing overutilization of healthcare services through income appropriate cost-sharing reforms; and**
- **Enacting common sense medical liability reforms.**

Data Notes:

(1) Existing Legislative Medicare Cuts Include:

- ACA Cuts: The impact shown reflects the ACA-authorized hospital/health system payment cuts and includes: update factor cuts (all-provider settings); payment cuts and changes related to the mandatory quality-based payment reforms of value-based purchasing, the readmissions reduction program, and the hospital-acquired conditions payment policy (inpatient hospitals); and Medicare disproportionate share hospital (DSH) payment cuts (inpatient hospitals). The impact shown does not capture ACA update factor cuts implemented prior to 2013 that carry forward additional negative impacts in the budget window analyzed.

- Sequestration Cuts: The impact shown reflects the BCA-authorized 2.0 percent sequester reduction on

total Medicare payments for a nine-year period (2013-2021 - the two-month delay in sequestration cuts legislated under the ATRA is accounted for in this analysis). CMS had not released guidance on how sequestration would be implemented at the time of this analysis. It was assumed that the 2.0 percent adjustment would be applied to all Medicare lines of payment, including those outside of the PPS rate and not included in this impact estimate, i.e., Direct Graduate Medical Education. Payments to Medicare Advantage plans will also be reduced, but the potential effect on providers will depend on the terms of each individual contract.

- Bad Debt Payment Cuts: The impact shown reflects the Middle Class Tax Relief and Job Creation Act of 2012-authorized reduction to Medicare payments for reimbursable bad debts for all provider settings to 65 percent.

- Coding Adjustment Cuts and Radiosurgery Payment Cut: The impact shown reflects the ATRA-authorized retrospective (one-time) coding adjustment cuts totaling at least -9.7 percent that CMS must implement over a four-year period (FFY 2014-2017). The impact of the ATRA provision that reduces the outpatient payment amount for certain stereotactic radiosurgery services beginning April 1, 2013 and thereafter is also shown.

(2) Existing Regulatory Medicare Cuts Include:

- Coding Adjustment Cuts: The impact shown reflects the CMS-imposed prospective (permanent) coding adjustment cuts of 1.9 percent (0.5 percent for hospitals paid at the hospital-specific rate) in 2013 (inpatient hospitals) and a 1.32 percent in 2013 (home health providers). The impact shown does not capture CMS coding adjustment cuts implemented prior to 2013 that carry forward additional negative impacts in the budget window analyzed.

(3) Additional Medicare Cuts Under Consideration Include (this analysis excludes cost of proposed post-acute care cuts):

- Outpatient E/M Cuts (source: H.R. 3630): The impact shown reflects the U.S. House-approved policy from 2011 to cap payment to hospitals for outpatient evaluation and management services at the payment level provided to physicians under the Medicare physician fee schedule. Due to data limitations, impacts for flat rate and specialty hospitals subject to this cut are not shown in this analysis.

- IME Cuts (source: Simpson-Bowles Commission): The impact shown reflects the recommendation to cut inpatient Indirect Medical Education payments in half by reducing the IME reimbursement percentage of 5.47 percent to 2.2 percent.

- GME Cuts (source: Simpson-Bowles Commission): The impact shown reflects the recommendation to limit teaching hospital's Direct Graduate Medical Education reimbursement to 120 percent of the national average salary paid to residents in 2010, updated annually thereafter.

- Bad Debt Payment Cuts (source: Simpson-Bowles Commission): The impact shown reflects the recommendation to eliminate payment for reimbursable bad debts for all provider settings.

- SCH Program Elimination (source: Congressional Budget Office): The impact shown reflects the recommendation to eliminate special inpatient payment status for sole community hospitals.

- CAH Payment Cuts (source: Congressional Budget Office): The impact shown reflects a reduction in reasonable cost-based reimbursement to critical access hospitals from 101 percent to 100 percent for inpatient, outpatient, and swing-bed services.

Health Care Spending Growth Hits Record Low

Since 2010, National Health Expenditures (NHE) have grown at an average annual rate of 3.8%. This represents the lowest rate on record for any four-year period* and is less than half of the average annual growth rate of 9.3% over the same timeframe. A key driver of this trend is the low rate of health care price inflation, for hospitals just 2.0% in 2013. Hospitals represent about a third of NHE.

These trends are leading to an improved long-term federal budget outlook. The Congressional Budget Office (CBO) projections of future Medicare spending from 2014 through 2020 are down by more than a half a trillion dollars.

Health care cost growth typically slows during recessions, but the continuation of this trend well into the recovery suggests more factors at hand. A growing body of recent research points to the impact of structural changes in how health care is delivered and financed.

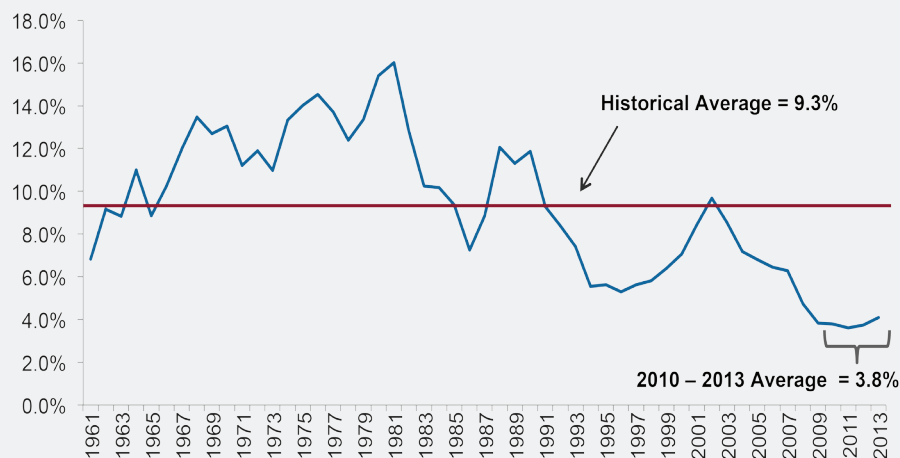
"The slowdown in health care cost growth has been sufficiently broad and persistent to persuade us to make significant downward revisions to our projections of federal health care spending."

— Douglas Elmendorf, Director, CBO

*Tracking of NHE data began in 1960.

Spending growth is at historically low levels.

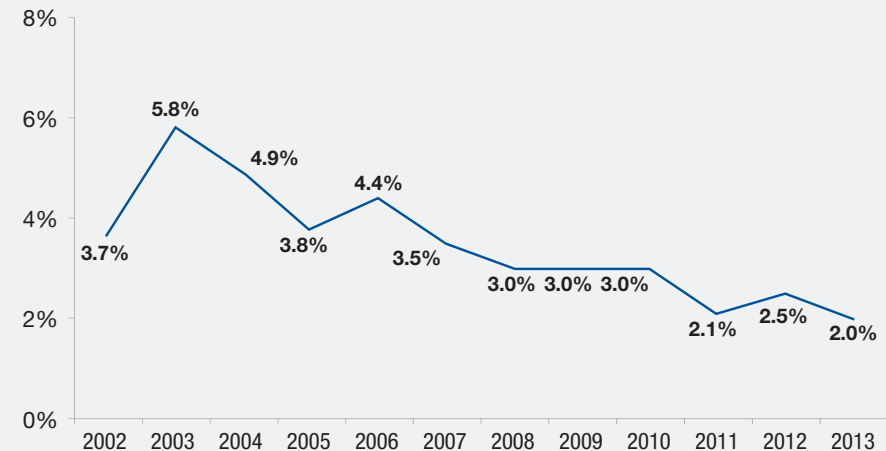
Percent Change in National Health Expenditures, 1961 - 2013



Source: 1960- 2012 from CMS Office of the Actuary, National Health Accounts. 2013 from Altarum Institute, February 11, 2014.

Low growth in hospital prices is an important contributor.

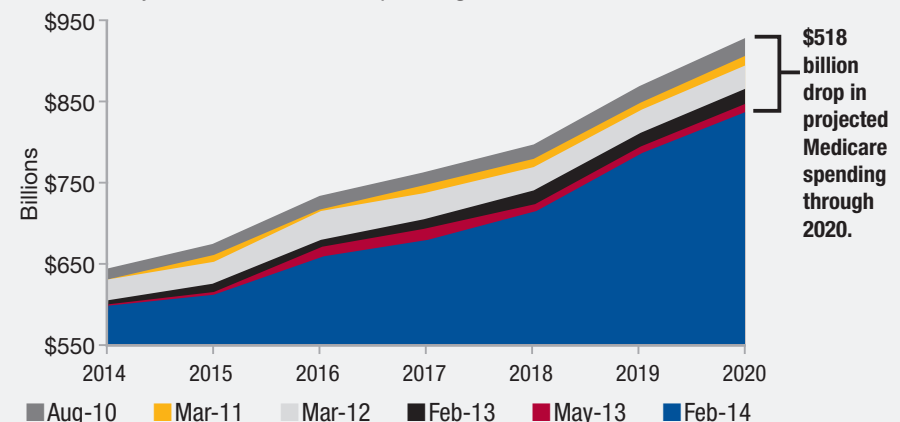
Annual Percent Change in Hospital Prices, 2002 - 2013



Source: Bureau of Labor Statistics. Producer Price Index data, 2002-2013, for Hospitals (622)

CBO projections of future Medicare spending are down substantially.

CBO Projections of Medicare Spending since 2010 for Fiscal Years 2014-2020



Source: Congressional Budget Office. Medicare Baselines for August 2010, March 2011, March 2012, and May 2013 and The Budget and Economic Outlook 2014-2024. Represents total mandatory outlays.

AHA's Issue Papers on Medicare Cuts

Outpatient Evaluation & Management Services

THE ISSUE

Congress is considering a 2011 Medicare Payment Advisory Commission (MedPAC) recommendation that would cap “total” payment for non-emergency department evaluation and management (E/M) services in hospital outpatient departments (HOPDs) at the rate paid to physicians for providing the services in their private offices.

However, in the 2014 outpatient prospective payment system (PPS) final rule, the Centers for Medicare & Medicaid Services (CMS) collapsed the 10 separate E/M codes for hospital outpatient clinic visits, and replaced them with one new code representing a single level of payment for all outpatient clinic visits. The previous

clinic visit codes reflecting five levels of resource intensity and the distinction between new and established patients are no longer recognized in the outpatient PPS. The adoption of a single code for all hospital outpatient clinic visits means a one-to-one coding match no longer exists to implement MedPAC’s recommendation.

MedPAC has not revisited its recommendation or its impact analysis since CMS finalized the E/M code collapse policy.

MedPAC had estimated its policy would reduce Medicare spending by \$900 million per year and \$9 billion over 10 years, by reducing hospital payment between 65 percent and 80 percent for 10 of the most common outpatient services.

AHA POSITION

Given CMS’s sweeping changes to the coding structure for E/M hospital outpatient clinic visit services, it is unclear how Congress could enact MedPAC’s ill-advised prior recommendation to equalize Medicare payment rates for E/M services between HOPDs and physician office settings. However, even if it is possible, the AHA strongly opposes such legislation because:

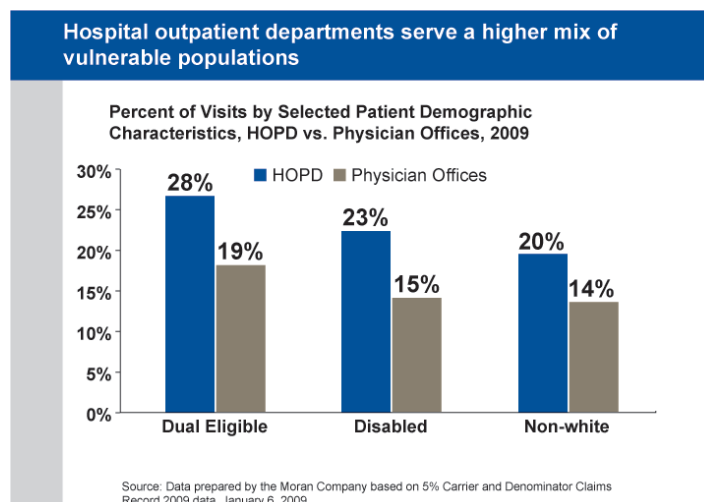
- Hospitals provide access to critical hospital-based services that are not otherwise available in the community and treat higher-severity patients for whom the hospital outpatient department is the appropriate setting.
- Hospitals have higher cost structures than physician offices due to the need to have emergency stand-by capacity.
- Hospitals have more comprehensive licensing, accreditation and regulatory requirements than physician offices.

WHY?

- **Hospitals already lose money treating Medicare patients in HOPDs.** According to MedPAC’s December 2013 public meeting, Medicare margins were *negative* 11.2 percent for outpatient services in 2012. Additional cuts to HOPDs threaten beneficiary access to these services.
- **Patients who are too sick for physician offices are treated in HOPDs.** Physicians refer more complex patients to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices, HOPDs treat patients with a higher average risk for complications.
 - An AHA analysis of Medicare data demonstrates that **patient severity** for E/M clinic visits, as measured using weighted hierarchical condition categories (HCC) scores, is nearly **24 percent higher in HOPDs than in physician offices.**

Continued on reverse

- **Hospital-based clinics provide services that are not otherwise available in the community to vulnerable patient populations.** The reduction in outpatient Medicare revenue to hospitals will threaten access to critical hospital-based services, such as care for low-income patients and services for patients with multiple conditions.
 - HOPDs serve a higher percentage of dual-eligible patients than physician offices. HOPDs also serve a higher percentage of disabled patients and non-white patients.



- **Hospitals have greater costs than physicians providing the same service in their offices.** HOPDs must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements than do free-standing physician offices. CMS acknowledged this in its July 19 proposed rule for the 2014 physician payment system:

“When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage, respectively.”¹

Unpaid “stand-by capacity” costs – such as around-the-clock availability of emergency services; cross-subsidization of uncompensated care, EMTALA and Medicaid; emergency back-up for other settings of care; disaster preparedness; a wide range of staff and equipment – make hospital-level care more expensive, and these costs are spread across all hospital services, including outpatient E/M services.

- **Teaching and safety-net hospitals would be hardest hit by the cuts.** Of special concern is the disproportionate impact that this policy would likely have on major teaching hospitals and public hospitals. Impact data from before CMS changed the clinic visits coding structure show that, while the overall cut to U.S. hospitals would be 2.8 percent, the impact more than doubles for major teaching hospitals, which would face a 5.6 percent cut, and in urban, public safety-net hospitals, which would face a 4.6 percent cut.
- **Payment should reflect HOPD costs, not physician payments.** HOPD payment rates are based on hospital cost report and claims data. In contrast, the physician payment schedule (and specifically the practice expense component) is based on voluntary responses to physician survey data held flat for years due to the cost of various physician payment “fixes.”
- **Capping E/M payment would lead to distortion of the hospital outpatient payment system.** Capping E/M payment as proposed would lead to significant distortions in the outpatient ambulatory payment classification (APC) relative weights due to the artificial payment caps that are no longer related to hospital costs. Each APC has a relative weight based on the geometric mean cost for the procedures in the group relative to the geometric mean cost for a mid-level E/M clinic visit.

¹ CMS-1600-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Proposed Rule (Vol. 78, No. 139), July 19, 2013, p. 43296.

Additional Hospital Outpatient Services at Risk for Site-Neutral Cuts

THE ISSUE

Congress is considering capping “total” payment for a set of 66 groups of services (referred to as ambulatory payment classifications (APCs)) furnished in hospital outpatient departments (HOPDs) at the rate paid to physicians for providing the services in their private offices. Based on its current analysis, the Medicare Payment Advisory Commission (MedPAC) indicates that this would cut hospital outpatient payments by 2.6 percent, or \$1.1 billion, in one year. This proposal reflects MedPAC discussions about expanding its “site-neutral” payment recommendation for hospital evaluation and management (E/M) services to other HOPD services. The services in these 66 APCs are routine outpatient services that are integral to hospitals’ service mission. However, MedPAC identified them as candidates for site-neutral cuts because MedPAC staff analysis showed that they met several criteria, including being frequently performed in physician offices, infrequently provided with an emergency department visit and having minimal patient severity differences across settings.

Under the policy being considered, a hospital would be paid a residual amount calculated as the difference between the payment rate the physician would receive under the Medicare Physician Fee Schedule (PFS) for a service furnished in his or her private office and the PFS rate paid for the service furnished in a HOPD. The policy would result in

steep cuts at the service level. For instance, under this policy and using data reflecting 2013 APC packaging policies, the hospital’s payment for a level II echocardiogram without contrast (APC 0269) would have dropped from \$387.13, the average amount paid in 2013 under the outpatient Prospective Payment System (PPS), to \$127.29 – a 67 percent reduction. This one service would have accounted for more than a quarter of MedPAC’s projected savings.

At its January 2014 meeting, despite AHA’s urging, MedPAC voted to formally recommend this policy without considering the several sweeping changes made in the calendar year (CY) 2014 hospital outpatient PPS final rule that likely have a substantial impact on its site-neutral payment policy and its associated savings estimate. In particular, the outpatient PPS final rule identifies five new categories of items and services whose costs are now packaged into the payment for other services to which they are integral, ancillary or supportive. This policy significantly increases the amount of packaging in all APCs and will likely affect the impact estimates for the 66 APCs site-neutral payment recommendation. In addition, the vote occurred amid continued stakeholder and commissioner concerns that the likely steep payment cuts could have unintended consequences for patient access to care and hospitals’ ability to continue to provide emergency standby services.

AHA POSITION

The AHA strongly opposes legislative proposals to reduce Medicare payment rates for these 66 APCs to a residual amount of the PFS payment rate or to the rate paid in Ambulatory Surgery Centers (ASCs).

While the MedPAC approach has generated a great deal of interest in Congress as a way to generate significant savings for the federal government, an alternate site-neutral proposal being considered by MedPAC and Congress would base payments for HOPD services on the rates Medicare pays for services in ASCs. The impact of this alternate approach also would be significant; currently, Medicare pays for covered surgical

services in ASCs at approximately 60 percent of the rate that it pays for similar services in the HOPD. MedPAC is considering a policy that would reduce HOPD payment for 12 APCs that are commonly performed in ASCs to the ASC level. MedPAC estimates that this policy would reduce hospital outpatient revenues by \$590 million per year or a 1.7 percent decrease in HOPD Medicare revenue.

Continued on reverse

Unlike physician offices and ASCs, hospitals play a unique and critical role in the communities they serve by providing a wide range of acute-care and diagnostic services, supporting public health needs, and offering many other services that promote the health and well-being of the community. In addition, hospitals provide emergency standby services such as:

- **24/7 Access to Care:** Providing health care services, including specialized resources, 24 hours a day, seven days a week (24/7), 365 days a year.
- **The Safety Net:** Caring for all patients who seek emergency care regardless of ability to pay.
- **Disaster Readiness and Response:** Ensuring that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions.

These critical roles, while often taken for granted, represent essential components of our nation's health and public safety infrastructure. **It is critical that Congress**

consider these unique roles of hospitals and refrain from imposing site-neutral payment cuts on HOPD services.

For example, hospitals currently provide \$46 billion of uncompensated care annually. By contrast, many physicians and ASCs do not serve Medicaid and charity care patients.

In addition, despite its importance, hospitals' standby role is not explicitly funded. There is no payment for a hospital and its staff to be at the ready until a patient with an emergency need arrives. Without such explicit funding, the standby 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, ASCs or any other type of provider.

Hospitals today face challenges in maintaining this role, such as increasing demand, staffing and space constraints, greater expectations for preparedness, the erosion of financial support from government payers, and the loss of patients to other settings that do not have the added costs of fulfilling the standby role.

WHY?

- Hospitals already lose money treating Medicare patients in HOPDs. According to MedPAC's Dec. 2013 public meeting, Medicare margins are negative 11.2 percent for outpatient services. Additional cuts to HOPDs threaten beneficiary access to these services.
- HOPDs provide services that are not otherwise available in the community to vulnerable patient populations. The reduction in outpatient Medicare revenue to hospitals will threaten access to critical hospital-based services, such as care for low-income patients and services for patients with multiple chronic conditions.
- HOPDs serve a higher percentage of disabled patients than physician offices. HOPDs also serve a higher percentage of dual-eligible patients and non-white patients than physician offices and ASCs.
- Patients who are too sick for physician offices or too medically complex for ASCs are treated in the HOPD. Physicians refer more complex patients to HOPDs for safety reasons, because hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices and ASCs, HOPDs treat patients with a higher average risk for complications.
- HOPDs have more comprehensive licensing, accreditation and regulatory requirements than do free-standing physician offices and ASCs.
- Payment 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 payment schedule (and specifically the practice expense component) 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 even report 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.



Site-neutral Payment Proposals Threaten Access to Care

Americans rely heavily on hospitals to provide 24/7 access to care for all types of patients, to serve as a safety net provider for vulnerable populations, and to have the resources needed to respond to disasters. These roles are not explicitly funded; instead they are built into a hospital's overall cost structure and supported by revenues received from providing direct patient care. Hospitals are also subject to more comprehensive licensing, accreditation and regulatory requirements than other settings.

Yet some policymakers want to make total payment for a service provided in a hospital the same as when a service is provided in a physician office or ambulatory surgery center (ASC).

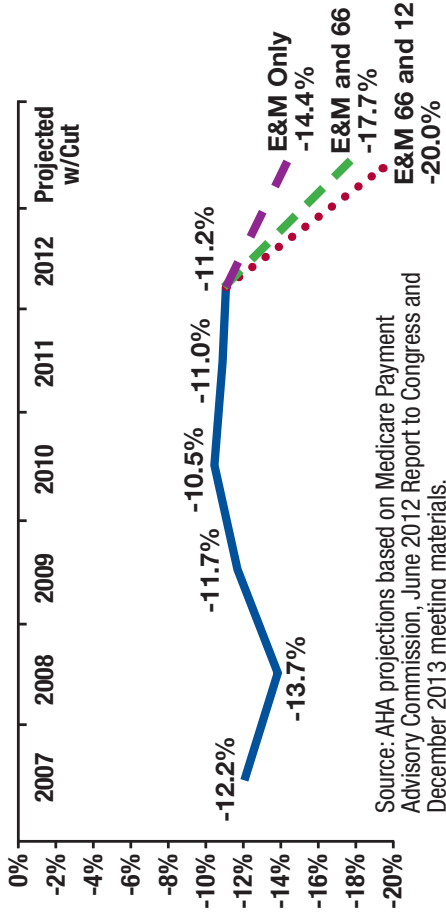
Lawmakers are considering three site-neutral payment changes that would result in lower payments to hospitals.

- Paying hospitals for evaluation and management (E/M) services in the hospital outpatient department (HOPD) setting at the physician fee schedule (PFS) amount
- Paying hospitals for 66 specified ambulatory payment classifications (APCs) at the PFS amount
- Capping hospital payments for 12 proposed APCs at the ASC rate

According to the Medicare Payment Advisory Commission's March 2013 report, Medicare margins are already negative 11 percent for outpatient services.

Implementing these policies would further erode HOPDs' Medicare margins, threatening access to care.

Medicare Margins for Hospital Outpatient Department Services, 2007-2011 and Projected with Proposed Cuts



Regulatory Requirements/Roles	Hospital Outpatient Department	Ambulatory Surgery Center	Physician Office
24/7 Standby Capacity for ED Services	✓		
Back up for Complications Occurring in Other Settings	✓		
Disaster Preparedness and Response	✓		
EMTALA Requirements	✓		
Uncompensated Care/Safety Net	✓		
Teaching/Graduate Medical Education	✓		
Special Capabilities (burn, trauma, neonatal, psychiatric services, etc.)	✓		
Required Government Cost Reports	✓		
Equipment Redundancy Requirements	✓		
Stringent Building Codes (ventilation systems, hallway widths, ceiling heights, etc.)	✓		
Infection Control Program	✓	✓	
Quality Assurance Program	✓	✓	
Joint Commission Accreditation	✓	✓	
Life and Fire Safety Codes	✓	✓	✓
Malpractice Insurance	✓	✓	✓
Admin Staff/Billing	✓	✓	✓
Medical Supplies	✓	✓	✓
Nurses	✓	✓	✓
Space and Utilities	✓	✓	✓

Assistance to Low-income Medicare Beneficiaries (Bad Debt)

THE ISSUE

The Medicare program requires its beneficiaries to pay a portion of the cost of their care, for example, through the inpatient hospital deductible of more than \$1,100 and through the outpatient hospital coinsurance of 20 percent. Many low-income beneficiaries cannot pay these amounts to the hospital, resulting in unpaid debt (sometimes referred to as “bad debt”). Historically, the Medicare program has reimbursed hospitals for a portion of the debt incurred by

Medicare beneficiaries, particularly those with low incomes. *The Middle Class Tax Relief and Job Creation Act of 2012* reduced these payments for prospective payment system (PPS) hospitals from 70 percent to 65 percent beginning in fiscal year (FY) 2013, and for critical access hospitals (CAHs) from 100 percent to 65 percent, phased-in over three years beginning in FY 2013. Thus, for CAHs, Medicare will pay 88 percent of allowable bad debt in FY 2013, 76 percent in FY 2014, and 65 percent in 2015 and beyond.

AHA POSITION

Reject further cuts to hospital payments for assistance in covering the debts of low-income Medicare beneficiaries.

WHY?

- **Reducing or eliminating this reimbursement disproportionately affects hospitals that treat high numbers of low-income Medicare beneficiaries – safety-net hospitals and rural hospitals:**
 - It leaves safety-net hospitals with less ability to serve low-income Medicare beneficiaries, who may not be able to afford cost-sharing requirements.
 - It puts rural hospitals and the patients they serve under severe stress, as their small size leaves them with more limited cash flow and less of an ability to absorb such losses. In addition, rural hospitals have Medicare bad debt levels that are 50 percent higher than urban hospitals, on average.
- **Medicaid frequently underpays beneficiaries’ Medicare cost-sharing obligations, leading to high levels of dual-eligible beneficiary debt. Dually-eligible beneficiaries account for roughly 20 percent of Medicare beneficiaries, but about 59 percent of hospitals’ Medicare bad debt.**
- **The Medicare program already pays less than the cost of providing care to Medicare beneficiaries.** Reductions exacerbate this problem, especially for those hospitals that serve many low-income beneficiaries. Cutting reimbursement to hospitals for assistance to cover the debts of low-income Medicare beneficiaries while still paying less than the cost of care to Medicare beneficiaries is inappropriate.
- **Under Medicare’s statutory reasonable cost principles, costs of care that are attributable to Medicare beneficiaries cannot be shifted to non-Medicare patients, and vice versa.** Thus, when hospitals are unable to collect cost-sharing payments owed by Medicare beneficiaries, they record these payments as bad debt and are reimbursed a portion of that Medicare debt directly from the Centers for Medicare & Medicaid Services (CMS).
- **Medicare reimburses PPS hospitals for 65 percent of Medicare beneficiary debts.** Historically, Medicare reimbursed hospitals for 100 percent of Medicare beneficiary debt; however, the *Balanced Budget Act of 1997* reduced that to 75 percent in 1998, 60 percent in 1999, and 55 percent in 2000 and beyond. In the *Benefits Improvement and Protections Act of 2000*, Congress increased reimbursement to 70 percent when the negative effects of cutting payments for the most vulnerable and poor Medicare beneficiaries became evident. *The Middle Class Tax Relief and Job Creation Act of 2012* reduced it to 65 percent for PPS hospitals in 2013 and beyond.

Continued on reverse

KEY FACTS

- Beneficiaries' out-of-pocket expenses for Medicare can be significant. In 2013, the Part A hospital deductible is \$1,184 per benefit period. The Part B deductible is \$147 per year and the Part B coinsurance is 20 percent of the Medicare-approved payment amount. In addition, there is a Part B premium of about \$105 per month, which varies depending on the beneficiary's income. Although this premium cannot turn into bad debt, it still represents an out-of-pocket expense that could contribute to seniors' inability to pay their other out-of-pocket expenses – deductibles and coinsurance.
- About 20 percent of Medicare beneficiaries are dual eligibles – low-income seniors and younger persons with disabilities who are enrolled in both the Medicare and Medicaid programs. To qualify as a dual eligible, a beneficiary's income is generally limited to less than the federal poverty level (FPL) – \$11,490 for a single person in FY 2013. These Medicare beneficiaries receive coverage under Medicaid, as well as Medicaid's assistance in paying Medicare premiums and cost-sharing. Cost-sharing varies by state; however, Medicaid typically pays much less than the full deductible and coinsurance due. The unpaid amount is classified as Medicare bad debt. Beneficiaries with incomes above the dual-eligible qualification level but below 120 percent of the FPL also may qualify for Medicaid assistance in paying Medicare premiums and cost-sharing. For these beneficiaries as well, Medicaid typically pays much less than the full deductible and coinsurance due, and the unpaid amount is classified as bad debt.
- Inner-city urban communities have large numbers and high proportions of Medicaid recipients and uninsured residents, and are highly likely to have large numbers and high proportions of low-income Medicare beneficiaries.
- Hospitals in the highest quartile of disproportionate share hospital (DSH) patient percentages have Medicare bad debt reimbursement as a percentage of their Medicare revenue that is more than two times higher than hospitals in the lowest quartile of DSH patient percentages, on average.
- About half of Medicare beneficiaries have incomes between 100 and 300 percent of the FPL, and cost sharing can represent a substantial portion of their income – they often cannot afford it.
- Below is an example of the cost sharing that would be incurred by a Medicare beneficiary with one hospital stay and associated physician visits in 2013 (in addition to this cost sharing, the beneficiary will have paid approximately \$1,260 in Part B premiums for the year).

Service	Medicare-approved Payment	Beneficiary Cost-sharing
Inpatient Hospital Stay	\$16,653	\$1,184
Physician	\$10,514	\$2,250
Total	\$27,167	\$3,434

CMS has set forth stringent criteria that must be met in order for unpaid Medicare deductibles and coinsurance to be reimbursed. For example, CMS requires that, to obtain reimbursement to cover the debts of Medicare beneficiaries, the hospital ensure that reasonable collection efforts were made and the debt was actually uncollectible. Hospitals must meet specific and detailed criteria to receive reimbursement.

A typical example of what a hospital must do in order to meet the criteria:

1. Upon admission and at discharge, the hospital lets the patient know that he/she has a deductible and copayment and that he/she will be billed when Medicare pays the hospital;
2. The patient receives an explanation of benefits from Medicare, which informs him/her of his/her liability;
3. When Medicare pays the hospital, the hospital sends a bill to the patient;
4. After 30 days with no payment, the hospital sends another bill to the patient;
5. After another 30 days with no payment, the hospital sends another bill to the patient;
6. The hospital follows up with a personal phone call to the patient;
7. After another 30 days with no payment, the hospital sends another bill to the patient;
8. The hospital follows up with another personal phone call and a collection letter to the patient;
9. After another 30 days, the hospital sends the bill to a collection agency;
10. After 90 days, the collection agency returns the bill to the hospital as uncollectible;
11. At this point, the hospital has satisfied Medicare's criteria and may claim reimbursement for the debt.



Graduate Medical Education

THE ISSUE

Some policymakers are advocating for a significant reduction in Medicare graduate medical education (GME) payments to teaching hospitals. The president's fiscal year (FY) 2014 budget called for reducing the indirect medical education (IME) adjustment by 10 percent, from 5.5 percent to 5.0 percent, which would cut Medicare medical education payments by approximately \$11 billion over 10 years. The Simpson-Bowles deficit commission recommended

reducing the IME adjustment by 60 percent and limiting hospitals' direct GME payments to 120 percent of the national average salary paid to residents in 2010. The Simpson-Bowles changes would reduce Medicare medical education payments by an estimated \$60 billion through 2020. The Centers for Medicare & Medicaid Services (CMS) reduced IME payments by \$40 million in FY 2013 by including labor and delivery beds in the IME calculation.

AHA POSITION

Reject reductions in Medicare funding for indirect medical education and direct graduate medical education.

WHY?

- **Cuts to GME funding would jeopardize the ability of teaching hospitals to train the next generation of physicians.** Reductions to GME funding would have significant impact, including forcing teaching hospitals to eliminate staff, close training programs and eliminate services operating at a loss. The AHA opposes any cuts to GME funding because they would result in fewer physicians being trained and reduce access to care across the country.
- **Reductions in the IME adjustment would directly threaten the financial stability of teaching hospitals.** In February 2011, the Association of American Medical Colleges estimated the impact of federal IME cuts and found that a 60 percent reduction in IME payments could mean a loss of 72,600 jobs, \$653 million in state and local tax revenue, and \$10.9 billion to the U.S. economy.
- **The nation is already facing a critical shortage of physicians, and cuts to IME/direct GME would further exacerbate the problem.** Experts indicate that the nation could face a shortage of as many as 130,000 doctors by 2025. The expansion of health care coverage in 2014 is projected to require an additional 31,000 physicians. Physician shortages will hamper national efforts to improve access to care and may result in longer wait times for patients.
- **Limits on the number of Medicare-funded residency training slots constrain the ability of hospitals to train new physicians.** Given the current and projected shortage of physicians, especially in primary care and general surgery, the AHA continues to recommend that the 1996 cap on residency slots be lifted. We urge Congress to eliminate the 17-year freeze in the number of physician training positions Medicare funds by supporting the creation of at least 15,000 new resident positions (about a 15 percent increase in residency slots) as included in the *Resident Physician Shortage Reduction Act of 2013* (S. 577), introduced by Sens. Bill Nelson (D-FL), Harry Reid (D-NV) and Charles Schumer (D-NY).

Continued on reverse

KEY FACTS

Teaching hospitals serve a unique and critical role in the nation's health care system. They not only train future health care professionals but also conduct medical research and serve a distinct and vital role in delivering patient care. They are centers of research and innovation, helping to develop new treatments and cures, and provide highly-specialized services such as burn care. Yet Medicare does not cover the total cost of care provided to Medicare beneficiaries. In its March 2013 report, the Medicare Payment Advisory Commission indicated that the overall Medicare margin was *negative* 2.4 percent for major teaching hospitals and *negative* 5.4 percent for other teaching hospitals.

The Medicare program has long recognized its responsibility for funding its share of the direct and indirect costs for training health professionals.

IME payments are explicitly made to compensate for the higher costs associated with teaching hospitals, such as residents' "learning by doing," greater use of emerging technology and greater patient severity. The

IME payment adjustment is a percentage add-on to the hospital's inpatient prospective payment system, and it varies based on the intensity of the hospital's teaching programs as measured by the ratio of residents to hospital beds. The number of residents included in the calculation of the resident-to-bed ratio is capped at 1996 levels.

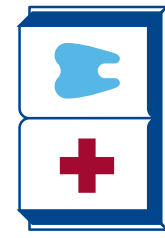
Direct GME payments help fund the teaching costs of residency programs, such as resident salaries and benefits, faculty salaries and benefits, and administrative overhead expenses. These payments are based on a hospital-specific, per-resident cost in 1984, updated annually for inflation. The per-resident payment amount varies by the residents' specialties. The resident count for most hospitals also is capped at their 1996 levels.

According to CMS, there are 1,038 teaching hospitals. Teaching hospitals directly employ 2.7 million people and are often among the largest employers in their communities. They are major economic engines, generating business, employment and tax revenue.

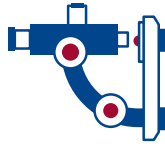
TEACHING HOSPITALS VITAL FOR TOMORROW'S HEALTH CARE

Teaching hospitals train future health care professionals, conduct medical research and fulfill a distinct and vital role in delivering patient care. While many hospitals offer comprehensive care, our nation's 1,041 teaching hospitals also deliver sophisticated diagnostic and treatment services. Teaching hospitals serve as economic engines of their local communities, providing millions of jobs and serving as hubs for biomedical research and other business activity.

1,000+ TEACHING HOSPITALS PROVIDE KEY BENEFITS



TRAINING EACH YEAR FOR 100,000
MEDICAL & DENTAL RESIDENTS



CRITICAL
MEDICAL RESEARCH

MEDICARE'S SUPPORT OF TEACHING HOSPITALS

Teaching hospitals receive Medicare funding to offset some of the costs associated with training medical and dental residents through direct graduate medical education (DGME) payments and are paid for high patient care costs associated with training residents – such as additional diagnostic testing – through indirect medical education (IME) payments.



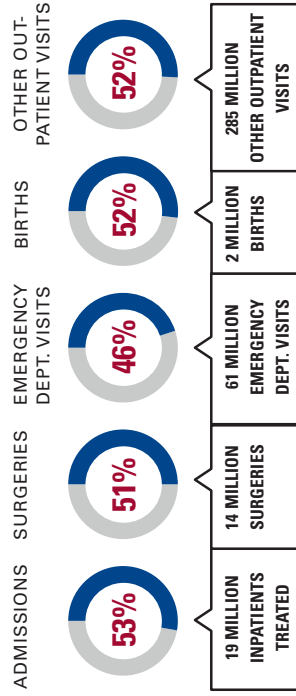
8.3 MILLION JOBS
SUSTAINED ACROSS
1,000+ COMMUNITIES

72,000 JOBS ARE AT STAKE
if the Simpson-Bowles deficit
commission's recommended
60% cut to Medicare's
indirect medical education
funding is enacted.



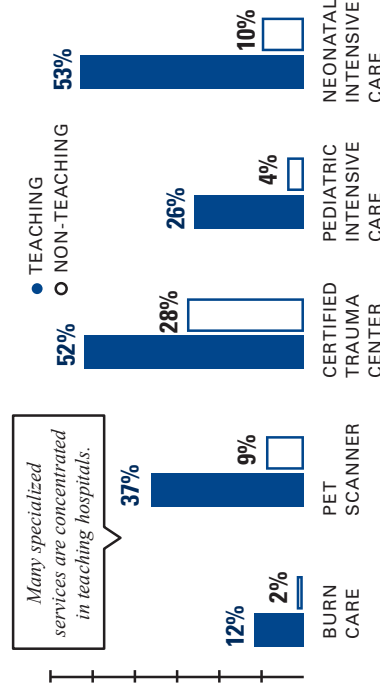
ALTHOUGH TEACHING HOSPITALS REPRESENT ONLY 1 IN 5 HOSPITALS, THEY DELIVER A MUCH LARGER SHARE OF THE NATION'S HEALTH SERVICES.

PERCENT AND ANNUAL NUMBER OF ALL HOSPITAL SERVICES PROVIDED BY TEACHING HOSPITALS



60% OF UNCOMPENSATED CARE THROUGHOUT THE NATION IS DELIVERED IN TEACHING HOSPITALS.

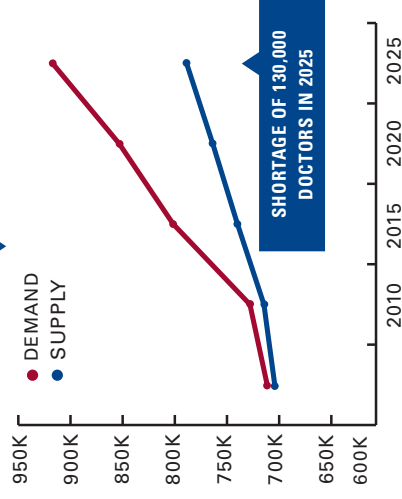
PERCENT OF HOSPITALS OFFERING SERVICE



THE EMERGING PHYSICIAN SHORTAGE CRISIS

The projected demand for active physicians is poised to increasingly outpace the supply of trained personnel. If anything, **more** resources should be invested in the next generation of doctors to fulfill our nation's future medical needs.

PROJECTED SUPPLY AND DEMAND FOR FULL-TIME EQUIVALENT PHYSICIANS ACTIVE IN PATIENT CARE, 2010 - 2025



THE 18-YEAR FUNDING FREEZE

IME payments are based on hospitals' ratios of residents to beds, and DGME payments are based on hospital-specific, per-resident costs. The number of Medicare-funded residency training positions has been frozen at 1996 levels; to address the looming shortage of doctors, the 18-year freeze must be ended and Medicare funding must keep pace with the nation's need for physicians.

INCREASE MEDICARE-FUNDED RESIDENCY POSITIONS TO PRESERVE THE MEDICAL LANDSCAPE OF TOMORROW – DON'T CUT FUNDING FOR TRAINING FUTURE CAREGIVERS.



SOURCES: 2012 DATA FROM AMERICAN HOSPITAL ASSOCIATION; ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Documentation and Coding

THE ISSUE

Beginning in fiscal year (FY) 2008, the Centers for Medicare & Medicaid Services (CMS) refined the method it uses to categorize patients for purposes of payment under the inpatient prospective payment system (PPS). The agency claimed that there would be improved documentation and coding for patient severity of illness as hospitals moved to the new system, which would result in higher payments. In response, Congress initially required CMS to make prospective cuts to hospital payments to account for these higher payments, as well as to make retrospective cuts, if necessary, to recoup overpayments

from FYs 2008 and 2009. In the *American Taxpayer Relief Act of 2012 (ATRA)*, Congress required CMS to recoup alleged overpayments made in FYs 2010-2013, an additional cut to hospitals of \$11 billion. The law also clarified that the Secretary of Health and Human Services has the authority to make an additional prospective documentation and coding cut of 0.8 percent to remove what it claimed were increased FY 2010 payments from the system. Although this cut was proposed by CMS but subsequently withdrawn, some policymakers are interested in this additional cut as part of deficit reduction.

AHA POSITION

Reject any further documentation and coding cuts to hospital payments.

WHY?

- **For America's already financially strained hospitals, an additional reduction in Medicare payments could result in the loss of health services and programs that are essential for Medicare beneficiaries, as well as other patients.**
- **The Medicare program already pays less than the cost of providing care to Medicare beneficiaries.** The Medicare Payment Advisory Commission found that overall Medicare margins declined from negative 4.5 percent in 2010 to roughly negative 5.8 percent in 2011 and projected they will decline further to negative 6.0 percent in 2013. In FY 2011, almost two-thirds (64 percent) of hospitals lost money serving Medicare patients. Additional cuts are not warranted.
- **CMS's estimate of the effect of documentation and coding and, therefore, the cuts the agency has already made, are overstated. CMS asserted that a total prospective cut of 5.4 percent was necessary.** However, AHA's analysis indicates that this prospective adjustment should have totaled 3.5 percent and that no further cuts were warranted related to case-mix change in 2010. This 1.9 percent difference will inappropriately reduce hospital payments by \$2.1 billion in FY 2013, and amounts to a cut of \$22.6 billion over the next 10 years. Now Congress has added another cut of \$11 billion, bringing the total value of excess cuts to hospitals to nearly \$34 billion.
- **It is inappropriate to consider even more cuts to hospitals based on a flawed methodology.** CMS continues to compare hospital documentation and coding in FY 2010 to documentation and coding under a diagnosis-related group (DRG) system that was discarded in FY 2007. The inpatient PPS changed substantially from FY 2007 to FY 2010. For example, the 2010 system utilized cost-based (rather than charge-based) data, allowed up to 25 (rather than nine) diagnoses codes per claim, and used a completely reformed list to document patient complications and comorbidities. Yet, CMS continues to believe that the case-mix index should be the same when using the new versus old system to measure patient severity levels in 2010. It is time to fully embrace the new improved system and to stop comparing it to the prior, obsolete system.

Continued on reverse

- **Medicare pays hospitals under a PPS, which allows providers to reasonably estimate payments in advance.** A PPS should be simple, transparent and predictable over time. Congress already has required CMS to make one set of prospective cuts and retrospective recoupments. Instituting further cuts flies in the face of the purpose of a PPS – to give providers the ability to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions.

KEY FACTS

Under the inpatient PPS, each patient's case is categorized into a DRG that has a set payment rate. Beginning in FY 2008, CMS began a transition to a more refined DRG system, known as Medicare Severity-DRGs (MS-DRGs), because the prior DRG system was found to inadequately account for differences in patient acuity. However, the agency claimed that changes in hospital documentation and coding practices in response to the new system would lead to increases in case mix – and associated payments – that did not reflect real changes in patient acuity. Therefore, it planned to adjust payments to remove what it estimated to be the documentation and coding effect.

In response, Congress required CMS to apply an adjustment of negative 0.6 percent in FY 2008 and negative 0.9 percent in FY 2009 to inpatient payments. They also specified that, to the extent that these two adjustments were over- or under-stated relative to the actual amount of documentation and coding-related change, CMS should make additional prospective cuts, as well as retrospective cuts to recoup the remaining overpayments. The agency implemented a prospective cut of 2.0 percent in FY 2012 and 1.9 percent in FY 2013, for a total prospective cut of 5.4 percent. In addition, it implemented a retrospective cut of 2.9 percent in both FYs 2011 and 2012, for a total recoupment of 5.8 percent. CMS's recoupment of overpayments in FYs 2008 and 2009 will be complete as of the end of FY 2013.

The ATRA requires the secretary to make a temporary adjustment to the standardized amount in FYs 2014, 2015, 2016 and 2017 to recoup overpayments that occurred in FYs 2008 through 2013 during the transition to MS-DRGs. These overpayments, estimated to be \$11 billion dollars, allegedly occurred because the prospective adjustments made in each year did not fully offset the additional payments made because of documentation and coding change. The AHA does not agree with this analysis.

In addition, for FY 2013, CMS proposed a new cut of 0.8 percent to permanently remove what it claims were increased FY 2010 payments from the system. An AHA analysis found that much smaller documentation and coding adjustments were necessary than what CMS implemented. These analyses indicate that much of the change CMS found is actually the continuation of historical increases in patient severity, not the effect of documentation and coding changes due to the implementation of the MS-DRGs. Specifically, AHA data indicate that CMS's prospective adjustment should have totaled 3.5 percent, not 5.4 percent. CMS's current cuts are excessive and the additional cuts added by ATRA are even more so. It is inappropriate for the agency to continue to compare hospital documentation and coding in FY 2010 and beyond to documentation and coding under a DRG system that was discarded in FY 2007. CMS withdrew its proposal for the new 0.8 percent cut in its FY 2013 final rule. CMS agreed with AHA's position that a smaller cut would be appropriate in its FY 2014 proposed and final rules. CMS has not implemented this cut at this time.

The 340B Drug Pricing Program

THE ISSUE

Section 340B of the *Public Health Service Act* requires pharmaceutical manufacturers participating in the Medicaid drug rebate program to sell outpatient drugs at discounted prices to taxpayer-supported health care facilities that care for uninsured and low-income people. The program enables eligible entities, including hospitals and community health centers, to stretch scarce federal resources to reduce the price of pharmaceuticals for patients, expand services offered to patients and provide services to more patients. In addition, the program generates savings for both the federal and state governments.

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

from high drug costs to safety-net providers through the establishment of the 340B Drug Pricing Program.

Section 340B covered entities include community health centers, children's hospitals, hemophilia treatment centers, critical access hospitals (CAHs), sole community hospitals (SCHs), rural referral centers (RRCs), and public and nonprofit disproportionate share hospitals (DSH) that serve low-income and indigent populations.

According to the Health Resources and Services Administration (HRSA), the federal agency responsible for administering the 340B program, enrolled hospitals and other covered entities can achieve average savings of 25 to 50 percent in pharmaceutical purchases. Despite recent HRSA efforts to exert more 340B program oversight and the program's proven record of decreasing government spending and expanding patient access, some in Congress are likely to continue their close scrutiny of the program and may attempt to scale it back, or significantly reduce the benefits eligible hospitals and their patients receive from the program.

AHA POSITION

The AHA opposes efforts to scale back or significantly reduce the benefits of the 340B program.

The AHA believes the 340B program is essential to helping safety-net providers stretch limited resources to better serve their communities.

The AHA supports extending the 340B discounts to the purchases of drugs used during inpatient hospital stays, expanding the program to certain rural hospitals, and eliminating the orphan drug exclusion for certain 340B hospitals.

The AHA supports program integrity efforts to ensure this vital program remains available to safety-net providers and encourages HRSA to develop a process to help financially distressed providers meet new program integrity provisions.

Continued on reverse

WHY?

- **Many 340B-eligible hospitals are the safety net for their communities.** The program allows these hospitals to further stretch their limited resources and provide additional benefits and services to their communities.
- **Better program oversight and clear program guidance will help 340B hospitals.** But program policy changes should occur with stakeholder consultation and allow for reasonable transition periods.
- **Expansion of the program would be a “win-win” for taxpayers, as well as for hospitals.** Expanding the 340B program would generate savings for the Medicaid program by requiring hospitals to rebate Medicaid a percentage of their savings on inpatient drugs administered to Medicaid patients. This change also would reduce Medicare costs, as CAHs are paid 101 percent of their inpatient and outpatient costs by Medicare, and the 340B pricing mechanism would lower CAHs’ drug costs. According to the Congressional Budget Office, expanding the program to cover inpatient services would save the federal government upwards of \$1.2 billion.

KEY FACTS

HRSA has implemented several 340B program integrity measures. These include audits of drug manufacturers and 340B entities and annual recertification for 340B entities. These measures stem from a 2011 Government Accountability Office report that criticized HRSA’s oversight of the 340B program. As a result of preliminary findings from hospital-based 340B audits, HRSA in February issued a 340B Drug Pricing Program notice to clarify program policy regarding the statutory prohibition against obtaining outpatient drugs through a group purchasing organization (GPO). Disproportionate share, children’s and free-standing cancer 340B hospitals are prohibited from using GPOs to make any outpatient drug purchases, but they may purchase all inpatient drugs through a GPO.

HRSA initially allowed covered entities 60 days after the publication of the GPO policy notice (until April 7, 2013) to make certain their 340B inventory management practices complied with the GPO policy. Based on feedback from AHA and its 340B member hospitals, HRSA extended the compliance deadline until Aug. 7, 2013 to allow time for

stakeholders to make the necessary changes.

HRSA in July 2013 finalized its regulation implementing the orphan drug exclusion for RRCs, CAHs and free-standing cancer hospitals. The final rule allows RRCs and CAHs to purchase orphan drugs, as long as these drugs are not used to treat rare conditions or diseases, which limits the exclusion for these hospitals and provides them greater access to 340B discounted drugs. AHA supports HRSA’s limitation on the orphan drug exclusion. In addition, the rule included several AHA supported modifications such as allowing hospital subject to the exclusion to establish an alternative compliance system and permitting free-standing cancer hospitals to opt out of using the 340B program to purchase orphan drugs and instead purchase the orphan drugs through a GPO. The Pharmaceutical Research and Manufacturers of America filed a lawsuit in federal district court to stop HRSA’s implementation of the orphan drug final rule. AHA filed an amicus brief supportive of HRSA’s interpretation of the orphan drug exclusion.

340B HOSPITAL ELIGIBILITY

340B Eligible Hospital	DSH%	GPO Prohibition	Orphan Drug Exclusion
Disproportionate Share Hospital	>11.75%	Yes	No
Children’s Hospital	>11.75%	Yes	No
Cancer Hospital	>11.75%	Yes	No
Critical Access Hospital	N/A	No	Yes
Sole Community Hospital	≥8%	No	Yes
Rural Referral Center	≥8%	No	Yes

*Source Apexus and HRSA, 2013

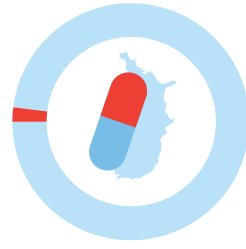


340B DRUG PRICING PROGRAM

PROTECTING THE SAFETY NET

For more than 20 years, Congress has provided relief from high prescription drug costs through the 340B Drug Pricing Program. The program requires participating pharmaceutical companies to sell covered outpatient drugs at a discount to eligible health care organizations. To be eligible, hospitals must serve a disproportionate share of uninsured and low-income patients. This program gives patients better access to drugs they need and helps hospitals enhance care capabilities by stretching scarce federal resources.

Small Program, Big Benefits

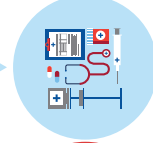
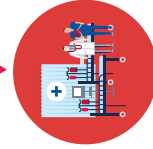


2%

Portion of the United States' \$325 billion in annual drug purchases made through the 340B program

\$1.6—\$3.2 BILLION

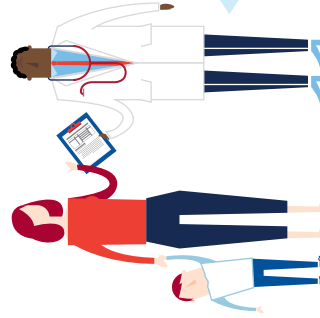
Total annual savings for 340B eligible providers



340B creates valuable savings on outpatient drug expenditures to reinvest in patient care and health activities to benefit the communities they serve. It also saves money for state and federal governments.

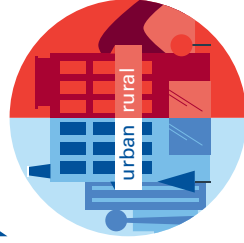
62%

Percentage of all uncompensated care provided by 340B hospitals



340B increases access to care for our most vulnerable populations - participating hospitals provided \$28.6 billion in uncompensated care in 2012.

Who Are 340B Hospitals?



About **half** are urban; half are rural.



864 (41.6%) are critical access hospitals (CAHs).



Located in **1,476 or 46%** of all US counties.

340B Hospitals Meet Rigorous Requirements

340B ELIGIBILITY

Hospitals must:

- ✓ Be designated as a not-for-profit hospital.
- ✓ Be classified as a Children's Hospital, Cancer Hospital, Sole Community Hospital, Rural Referral Center, Critical Access Hospital or a Medicare Disproportionate Share Hospital.
- ✓ Serve a large proportion of uninsured and low-income patients.
- ✓ Undergo random audits by the federal government and pharmaceutical manufacturers.
- ✓ Recertify annually as an eligible 340B provider.
- ✓ Maintain auditable inventories for 340B and non-340B prescription drugs.

PRESERVE THE 340B PROGRAM; PROTECT THE SAFETY NET

SOURCES: HEALTH RESOURCES AND SERVICES ADMINISTRATION; IMS HEALTH; 2012 AMERICAN HOSPITAL ASSOCIATION ANNUAL SURVEY DATA; APEXUS



Long-term Care Hospitals

THE ISSUE

Long-term care hospitals (LTCHs) serve a critical role within the Medicare program by treating the sickest patients who need long hospital stays. In December 2013, Congress passed the *Bipartisan Budget Act*, which, among other changes, implements several important reforms that will more clearly distinguish the LTCH role. These include a new, two-tiered payment system beginning in October 2015, under which LTCHs will be paid an LTCH-

level rate for patients with higher severity of illness levels, and a lower, “site-neutral” rate (comparable to general acute care hospitals) for patients with lower medical acuity.

In addition, the new law addresses the “25% Rule”, established by the Centers for Medicare & Medicaid Services to limit referrals from one source, by implementing more manageable “25% Rule” thresholds for cost reporting periods beginning Oct. 1, 2013 through Sept. 30, 2017.

AHA POSITION

The AHA has long supported the development of criteria to distinguish LTCHs from general hospitals and other post-acute settings. The new LTCH criteria in the *Bipartisan Budget Act* will appropriately focus Medicare’s LTCH resources on sicker patients. We also support the 25% Rule relief provided under this law, which will implement less burdensome levels of the policy to allow the field to focus on transitioning to the new payment system and to prepare for broader delivery system reforms, such as bundled payments. **Overall, the *Bipartisan Budget Act* will bring much-needed regulatory stability that will ensure access for the beneficiaries who need an extended hospital stay. However, some LTCH policies in the *Bipartisan Budget Act* require targeted technical adjustments to ensure the effective and fair implementation of the law.**

WHY?

■ **While the AHA is pleased that Congress addressed this issue, some of the LTCH policies in the *Bipartisan Budget Act* require closer review and consideration for limited technical corrections.** One provision in need of refinement is the definition of the cases that remain eligible for payment under the traditional LTCH prospective payment system (PPS). Under this law, LTCH PPS payments will apply to cases that, in the immediately prior inpatient PPS hospital stay, received either 3+ intensive care unit days of service or were discharged with a principle diagnosis based on 96+ hours of ventilator services. **While these LTCH PPS payment criteria are appropriate, a modest expansion should be considered to include high-acuity patients who do not meet the current criteria.**

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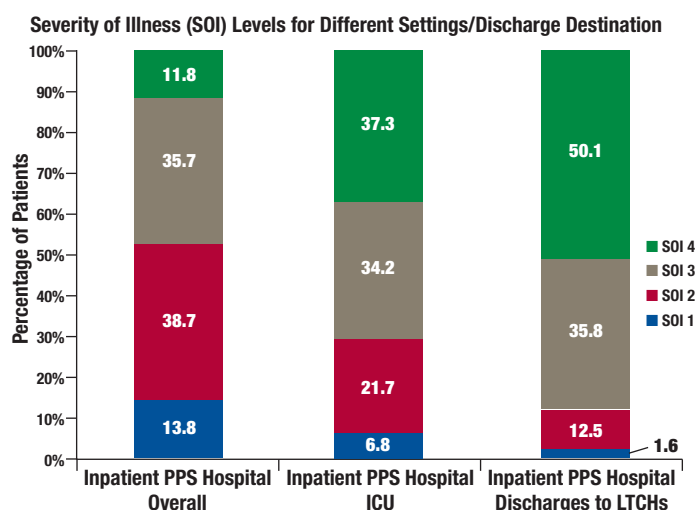
■ The *Bipartisan Budget Act* provision placing a cap on the site-neutral cases is also worthy of reconsideration. Under this provision, for cost reporting periods beginning Oct. 1, 2019, any LTCH with 51 percent or greater of its discharges paid a site-neutral rate would be subject to a major penalty – all discharges in future cost reporting periods will be paid the inpatient PPS rate. **However, this could result in an unwarranted penalty for LTCHs serving a low percentage of Medicare beneficiaries. Therefore, the denominator for the formula determining an LTCH’s compliance with the discharge cap should be more explicitly defined as “all [fee-for-service] Medicare beneficiaries discharged by the LTCH during the applicable cost reporting period.” In addition, Medicare Advantage cases in LTCHs should not be subject to this LTCH requirement since they are typically paid below LTCH PPS rates.**

The AHA will continue to monitor the implementation of the new LTCH PPS criteria and the need for additional technical corrections.

KEY FACTS

LTCHs Treat Severely Ill Patients

The LTCH patient population is more severely ill than patients treated in general acute care hospitals. Data from general acute hospitals show that patients discharged to LTCHs have the highest medical severity when compared to patients in other settings. For example, 50 percent of inpatient PPS patients discharged to an LTCH have a severity of illness (SOI) level 4 (extreme severity) compared to only 37 percent of patients in ICUs. Since LTCH patients are typically far sicker, their average length of stay (ALOS) is much longer: 27.2 days for LTCHs, 5.1 days for general acute hospitals, and 6.7 days for ICUs in general acute hospitals.



Source: Analysis of 2011 MedPAR data.

Inpatient Rehabilitation Facilities

THE ISSUE

Inpatient rehabilitation facilities (IRFs) have faced significant scrutiny from Congress and the Centers for Medicare & Medicaid Services (CMS) in recent years, which has led to multiple interventions, including strict criteria for IRF patients, multiple payment cuts and other policy restrictions. Collectively, these interventions have reshaped the population treated in IRFs by dramatically reducing the overall volume of IRF patients and steadily increasing the medical

complexity of patients treated in this distinct setting. The president's 2014 budget proposes three IRF cuts: returning the 60% Rule threshold back to 75 percent; paying IRFs a lower rate for selected patients who are also treated in skilled nursing facilities (SNFs); and cutting the annual market basket update. The proposals ignore these fundamental IRF shifts, and are now, in fact, unnecessary and detrimental to patients' access to the unmatched services provided by IRFs.

AHA POSITION

Reject further payment cuts for inpatient rehabilitation hospitals and units.

WHY?

- **Raising the “60% Rule” threshold is unnecessary since existing IRF admission rules strictly control who is admitted into an IRF.** These rules, implemented in January 2010, clearly set the IRF patient population apart from that of other post-acute settings, as shown in the table below. In addition, Medicare ensures that IRFs are admitting the right patients through audits. The president's proposal overlooks the substantial reduction in the number of beneficiaries admitted annually to IRFs over the last 10 years – more than 120,000 cases. It also ignores the fact that IRFs continue to treat sicker patients every year and produce better outcomes than SNFs. Further, in its March 2013 report to Congress, the Medicare Payment Advisory Commission (MedPAC) projected that IRF Medicare margins for 2013 will drop by 1.1 percentage point.
- **Medicare must not require IRFs to provide hospital-level services, but pay them SNF rates.** IRFs provide unique clinical value for patients who require hospital-level care and intensive rehabilitation after an illness, injury or surgery. Only in an IRF do beneficiaries receive three or more hours of therapy per day as part of a plan of care that is developed and overseen by a specialty physician and carried out by an inter-disciplinary medical team. As a result, the patient population and scope of services found in IRFs are highly distinct from those found in SNFs. IRF patients are medically complex and must require both hospital-level care and intensive rehabilitation services, which are not found in SNFs.

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KEY FACTS

IRFs treat clinically appropriate patients and offer higher intensity services than SNFs.

IRFs Treat Hospital-level Patients Only:

- In 2010, CMS implemented strict IRF admission criteria mandating that every patient require both hospital-level care and intensive rehabilitation. Therefore, IRFs are not allowed to admit SNF-level patients.
- The new criteria make the IRF patient population unique from patients in all other post-acute settings. SNFs and other post-acute settings do not have similarly rigorous admission criteria.

IRFs and SNFs Are Not Interchangeable:

- CMS reported in 2011 that IRFs have a far higher rate of discharging patients to the community (IRFs: 81%; SNFs: 46%); and far lower readmission rates (IRF: 9.4%; SNF: 22.0%).
- Medicare mandates that IRF physicians direct care delivery by interdisciplinary medical teams, which are not present in SNFs.
- Most nursing care in IRFs is provided by specially trained registered nurses (RNs), a far

higher level of nursing care than that provided in most SNFs.

- IRF patients must need and receive at least three hours of therapy per day, five days per week.
- IRFs, unlike other post-acute settings, submit admission and discharge data that demonstrate their value to beneficiaries. These data show IRF patients are continuing to experience improved functional outcomes – even as overall IRF patient complexity has increased.

IRF Volume Has Dropped Due to Regulatory Interventions:

- Through the 60% Rule, payment cuts, and new patient/facility criteria, Congress and CMS have significantly decreased the number of Medicare patients and payments for IRFs.
- Annual volume of IRF discharges dropped 123,712 cases from 2004 to 2011.
- MedPAC projects that Medicare margins for IRFs will drop in 2013.

IRFs vs. SNFs

Required by Medicare	IRFs	SNFs
Close medical supervision by a physician with specialized training	Yes	No
24-hour rehabilitation nursing	Yes	No
Multidisciplinary team approach	Yes	No
3 hours of intensive therapy; 5 days per week	Yes	No
Patients must require hospital-level care	Yes	No
Physician approval of preadmission screen and admission	Yes	No
Medical care and therapy provided by a physician-led multidisciplinary medical team including specialty trained registered nurses	Yes	No
Readmission rates to general acute hospitals	9.5% (2010)	19.2% (2011)
Discharge rate to community	71.0% (2010)	27.8% (2011)
2011 Medicare fee-for-service spending	\$6.54 billion	\$31.3 billion
Projected Medicare margins for 2013 (Freestanding SNF margins only)	8.5%	12-14%

The data cited in this document are drawn from the Medicare Payment Advisory Commission's March 2013 Report to Congress, and the FY 2012 SNF Final Rule.



Medicaid Provider Assessments

THE ISSUE

The Medicaid provider assessments program has allowed state governments to expand coverage, fill budget gaps and maintain patient access to health services to avoid additional provider payment cuts by helping states finance their portion of the joint federal/state program. Some policymakers have called for restricting states' ability to use assessments as a financing tool. The president's fiscal year (FY) 2013 budget proposed to phase down, but not eliminate, Medicaid provider assessments beginning in 2015.

The administration estimated this would save \$21.8 billion over 10 years. The House approved its FY 2013 budget reconciliation package with cuts to Medicaid provider assessments of \$11.2 billion over 10 years. The Simpson-Bowles deficit commission also recommended restricting, and eventually eliminating, states' ability to use assessments on health care providers to finance a portion of their Medicaid spending. This proposal to eventually eliminate provider assessments would result in estimated reductions of \$44 billion in the Medicaid program by 2020.

AHA POSITION

Reject options that restrict states' ability to partially fund Medicaid programs using provider assessments.

WHY?

- **Provider assessment cuts are just another name for Medicaid cuts and harm the millions of children, poor and disabled Americans who rely upon this vital program.**
- **Further cuts to hospital funding would put enormous pressure on already stretched state budgets and could jeopardize this critical health care safety-net program.**
- **Hospitals already experience payment shortfalls when treating Medicaid patients.** Medicaid, on average, covers only 89 cents of every dollar spent treating Medicaid patients. Changes to the provider assessment program would further exacerbate this problem.
- **Currently, 67 million low-income Americans rely on the Medicaid program to provide access to health care. With implementation of the *Patient Protection and Affordable Care Act (ACA)*, as many as 13 million more people may be enrolled in Medicaid beginning in 2014 (based on May 2013 Congressional Budget Office estimates).** Any reduction or elimination of Medicaid provider assessments would be on top of Medicaid cuts made at the state level.

KEY FACTS

Over its 46-year history, Medicaid has become the nation's health care safety net, serving as a buffer to the perils of an uncertain economy by providing access to health services for those who cannot afford private insurance. This role has never been more critical than it is in today's struggling economy. Medicaid is the safety net for millions of Americans, and its coverage role is expanding under the ACA.

Nearly all states employ some form of provider assessments – on hospitals, intermediate care facilities, nursing homes, managed care organizations or

pharmaceuticals – as a means to obtain funds for their Medicaid programs.

A provider assessment, which also may be referred to as a fee or tax, is a mandatory payment imposed on providers by a state. Under federal law, these assessments cannot exceed 25 percent of the state share of Medicaid expenditures. Such an assessment must be: "broad based" (must cover at least all non-federal, non-public providers in a class – not just those who receive Medicaid payments); applied uniformly to all providers in a class; and without a "hold harmless" provision that

Continued on reverse

Continued

would guarantee a provider an offset for any portion of the cost of the assessment.

According to the Kaiser Family Foundation, Medicaid covers:

- 1 in 3 children
- 1 in 3 births
- 8 million people with disabilities
- Nearly 9 million low-income Medicare beneficiaries
- 1 in 4 poor non-elderly adults.

Medicaid also is the major payer for long-term care services for low- and middle-income elderly. Medicaid

pays for seven out of 10 people living in nursing homes. More than a quarter of all mental health funding is from Medicaid. And according to the Kaiser Family Foundation, during the recession from 2007 to 2009, 6 million people were covered by Medicaid who would have otherwise gone without health care coverage.

The provider assessment program is a critical component to funding Medicaid programs across the country. The program deserves a thoughtful, deliberate examination to design reforms that ensures the nation meets its obligation to care for the neediest of our society.

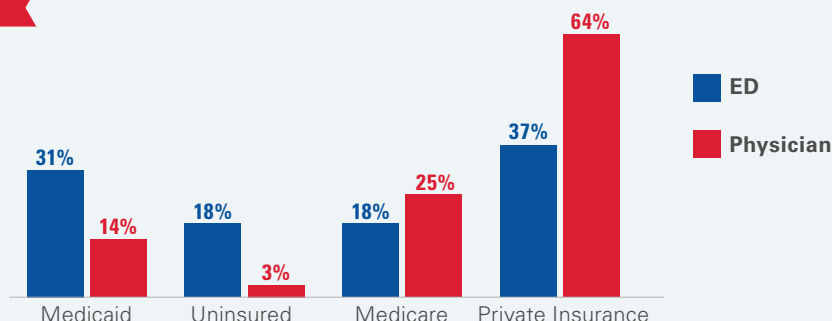


Hospitals must be prepared to treat more than **1,600 unique conditions** and require staffing in multiple areas:

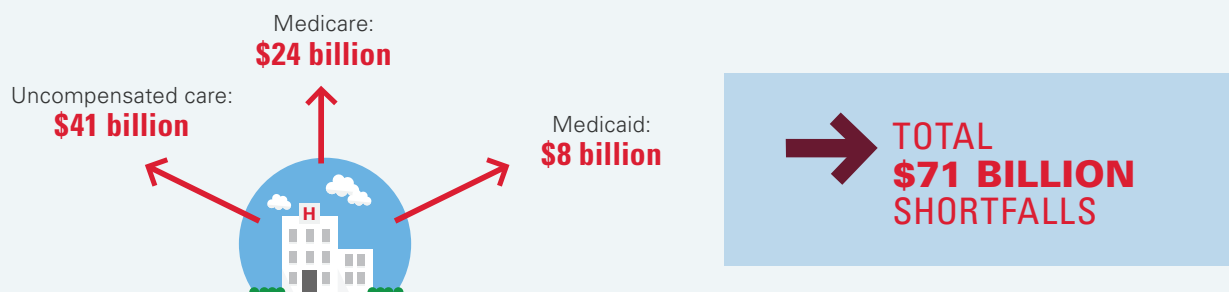


SAFETY NET

EDs serve more Medicaid and uninsured patients than physician offices

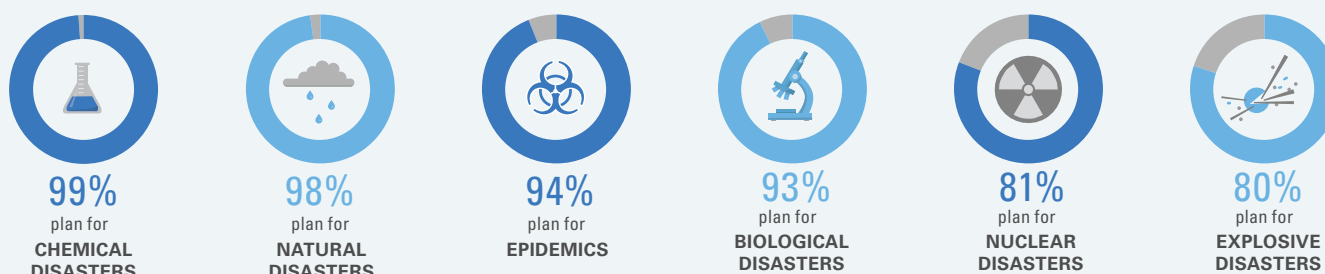


PAYMENT GAPS AT HOSPITALS



EMERGENCY READINESS

HOSPITALS PLAN FOR MULTIPLE DISASTERS



FEDERAL FUNDING FOR HOSPITAL PREPAREDNESS PROGRAM

(in millions)



Sources:

Ambulatory Health Care Data, Centers for Disease Control and Prevention. <http://www.cdc.gov/nchs/ahcd.htm>

"Prepared to Care: The 24/7 Standby Role of America's Hospitals." American Hospital Association. <http://www.aha.org/research/reports/preparedtocare.shtml>

American Hospital Association Annual Survey Data, 1990 to 2011.

Deficit Reduction Alternatives in Health Care

Summary of the Issue

Measures to curb federal spending by trimming Medicare and Medicaid payments are options in the current deficit reduction environment. Providers already face billions of dollars in Medicare and Medicaid payment cuts. Efforts to further cut Medicare and Medicaid payments to providers jeopardize access to high quality health care services for America's seniors and the poor. True entitlement reform and approaches to change the health care delivery system are needed – not provider cuts.

As congressional leaders and the administration have debated deficit reduction, several “plans” and proposals have emerged. These include:

- President Obama’s budget proposals
- House Budget Chairman Paul Ryan’s budget proposal
- The Congressional Budget Office’s report on options for reducing the Federal deficit
- The National Commission on Fiscal Responsibility and Reform (Simpson-Bowles)
- The Debt Reduction Task Force (Rivlin-Domenici)
- The “Gang of 6” US senators that developed a bipartisan plan to reduce the deficit
- House Majority Leader Eric Cantor’s list of spending reductions

These various plans proposed many types of deficit reduction provisions including across-the-board reductions or sequestration, formulaic and deadline-based “triggers” of budgetary action, and specific policy alternatives. Among these options, there are many health care policy alternatives that could be used to support deficit reduction that don’t simply cut Medicare and Medicaid payments. The following alternatives should be discussed and thoughtfully considered in any deficit reduction debate:

- Modernizing cost sharing for Medicare and Medicaid
- Increasing the eligibility age for Medicare
- Increasing the FICA tax to support Medicare Part A spending
- Implementing enhanced comparative effectiveness research and programs
- Improving programs to improve care at the end of life
- Developing programs to coordinate care for individuals eligible for both Medicare and Medicaid
- Applying Medicare reforms in the ACA (such as accountable care organizations, medical homes, bundling) to Medicaid
- Increasing use of generic drugs and biologicals
- Modernizing the Medicaid long-term care benefit
- Medical liability reform
- Taxing Cadillac health plans
- Taxing junk foods and sugary drinks

These types of reforms can be used to reduce spending, improve quality, better coordinate care, enhance personal responsibility, and modernize Medicare, Medicaid and the entire health care system.

Health Care Alternatives for Deficit Reduction

The following table provides more detail describing health care alternatives that were included in one or more of the various deficit reduction proposals and should be considered for deficit reduction.

Option	Description	Plans that include option	10-Year Savings
Medical Liability Reform	<p>Three of the plans included caps on non-economic and punitive damages. The most developed proposal in the CBO Options document would impose certain nationwide curbs on medical malpractice torts, capping non-economic damages to \$250,000; punitive damages at \$500,000 or two times the value awards for economic damages (whichever is greater); impose a “fair –share” rule (replacing joint-and-several liability); impose a statute of limitations for one year from the date of injury discover for adults; 3 years for children.</p> <p>Modify collateral source rule; impose a statute of limitations; replace joint-and-several liability with a fair-share rule; and create specialized “health courts,” allow safe havens for providers who follow best practices.</p>	<p>CBO Options Ryan Budget Rivlin-Domenici</p> <p>Simpson-Bowles</p>	<p>\$57 Billion (CBO proposal)</p> <p>\$17 Billion</p>
Reduce Medicare Costs by Changing Cost-Sharing Structures for Medicare Part A and B	<p>Establish a single combined annual deductible for Part A and B, along with a 20 percent coinsurance for spending above deductible up to a certain amount.</p> <p>Increase the basic premium for Medicare Part B and Part D from 25% and 25.5% respectively to 35% of the Program’s cost. When Part B began in 1966, the premium was intended to finance 50% of the Part B costs per enrollee.</p> <p>Prohibit Medigap plans from covering the first \$550 of an enrollee’s cost-sharing liabilities and limit coverage to 50% of the next \$4,950 in Medicare cost-sharing.</p>	<p>CBO Options Simpson-Bowles</p> <p>CBO Options Rivlin-Domenici</p> <p>Simpson-Bowles CBO Options Cantor List</p>	<p>\$52 Billion</p> <p>\$274 Billion</p> <p>Up to \$58 Billion</p>
Raise the Age of Eligibility for Medicare to 67	Raise the age of eligibility for Medicare by 2 months every year beginning with people who were born in 1949 until the eligibility age reached 67.	Ryan Budget CBO Options	\$23 Billion
Pharmaceutical Pricing	<p>Require manufacturers of brand-name drugs to pay the federal government a rebate on drugs purchased by enrollees in the low-income subsidy program. The program would reflect the current rebate system for Medicaid.</p> <p>Speed up availability of generic biologics, and prohibit brand-name companies from entering into a “pay for delay” agreements with generic companies. Implement Medicaid management of high prescribers and users of prescription drugs.</p> <p>Use Medicare’s buying power to increase rebates from pharmaceutical companies.</p>	<p>CBO Options Obama Budget Simpson-Bowles</p> <p>Obama Budget</p> <p>Obama Budget Rivlin-Domenici</p>	<p>\$123 Billion</p>
Slow the Growth of Federal Contributions for the Federal Employees Health Benefits Program (FEHBP)	Limit the federal government’s contribution to \$5,000 towards the cost of an individual premium or \$11,000 for a family premium beginning on 1/1/13. The federal contribution would then increase annually at the rate of inflation as measured by the CPI for all urban consumers, rather than at the average weighted rate of change in FEHBP premiums. Simpson-Bowles plan would include a similar pilot program for FEHBP.	CBO Options Simpson-Bowles Cantor List	\$31.5 Billion in Mandatory Spending; \$41.9 Billion in discretionary spending
Health Care-Related Revenues	<p>Standardize the base on which the federal excise tax on alcohol is levied by using the proof gallon as the measure for all alcoholic beverages.</p> <p>Replace the 0.9% surtax on high-income taxpayers with a 1.0 percentage point increase in the total HI tax on all earnings. The HI tax rate for both employers and employees would increase by 0.5 percentage points to 1.95%, resulting in a combined rate of 3.9%.</p> <p>Impose a federal excise tax of 3 cents per 12 ounces of “sugar-sweetened” beverage.</p> <p>Impose the excise tax on employment-based health care coverage above certain limits beginning in 2014 instead of in 2018.</p>	<p>CBO Options</p> <p>CBO Options</p> <p>CBO Options Rivlin/ Domenici</p> <p>CBO Options</p>	<p>\$64 Billion</p> <p>\$650.8 Billion</p> <p>\$50.4 Billion</p> <p>\$310 Billion</p>
Base Social Security COLAs and Other Entitlements on the Chained CPI-U	Some policymakers have discussed changing the measure of inflation for Social Security COLAs (CPI-W) and other entitlement program COLAs currently based on CPI-U to the “chained” CPI-U. Social security COLAs are currently based on the CPI-W (consumer price index for urban wage earners and clerical workers). The chained CPI-U (C-CPI-U) is an alternative measure of inflation (also calculated by the Bureau of Labor Statistics) that more fully incorporates the effects of changes in patterns of spending and which most economists and analysts believe more accurately reflects the actual increase in the cost of living.	CBO options (Social Security only)	<p>\$162 Billion (Social Security only)</p> <p>Effect on other entitlements unknown</p>

AzHHA's Position Paper on Regulatory Relief

Reducing Regulatory Red Tape: Improving Medicare Audit and Payment Processes

The Issue

Hospitals face significant challenges each year managing an enormous number of regulatory requirements, including complex and ever-changing payment and audit policies. While hospitals strive for billing accuracy, the combination of complexity, ambiguity and rigidity surrounding Medicare's payment rules make this a near Herculean task. Two Medicare programs epitomize the challenges that hospitals face.

The Recovery Audit Contractor (RAC) program began with the goal of ensuring accurate payments to Medicare providers. But due to the methodology by which RACs are paid, lax oversight, and a broken appeals process, the program has become a drain on hospitals, taking resources away from where they are needed most—patient care. Furthermore, RACs have been able to capitalize on one of the more complex clinical decisions that hospital personnel must make—whether or not to admit a patient as an inpatient. By targeting these “short stay admissions,” RACs second-guess the medical judgment of physicians and potentially transfer additional cost-sharing risk to Medicare beneficiaries.

The Centers of Medicare & Medicaid Services (CMS) recently responded to the “short stay debate” by adopting the two-midnight policy, whereby inpatient stays spanning two midnights will generally be considered appropriate for inpatient reimbursement. Hospital stays less than two midnights will generally be considered outpatient cases, regardless of clinical severity. Responding to concerns over the two-midnight policy, CMS and, more recently, Congress have partially delayed enforcement of it until March 31, 2015.

AzHHA's Position

AzHHA supports efforts to improve payment accuracy. But such accuracy depends on clear and pragmatic billing guidelines, as well as ongoing provider education. While many Medicare auditors work with providers to “get it right,” the RAC program’s contingency fee structure simply incentivizes contractors to target high-dollar claims. Moreover, audits that second-guess the clinical judgment of physicians—months and sometimes years after the fact—are particularly troubling to medical professionals and hospitals. AzHHA strongly supports efforts to reform the RAC program, including fixing the rebilling process. AzHHA also supports efforts to find a workable solution for short stay admissions.

Background

The national RAC program began in 2010 not for the purpose of investigating or fighting Medicare fraud, but for the purpose of identifying and correcting inaccurate Medicare payments. RACs are authorized to conduct automated and complex audits, the latter of which trigger detailed medical record reviews. RACs can request up to 400 medical charts every 45 days (600 for very large hospitals) and are generally not set up to accept electronic charts. Thus, complex audits require staff time and expense to make and mail copies, involving significant labor resources on the part of the provider.

RACs are just one of the many types of auditors employed by CMS. For example, Medicare Administrative Contractors (MACs) serve as providers' primary point-of-contact for enrollment and training on Medicare coverage, billing and claims processing. They also conduct pre-payment and post-payment audits. Unlike MACs and other Medicare auditors, RACs are paid on a contingency fee basis. Such commission fees place doubt on the ability of RACs to act as impartial judges of payment accuracy.

Over the years, hospitals and other providers have identified a number of concerns with the RAC program:

- **RACs are often inaccurate, inflicting avoidable legal and administrative costs on hospitals.**
 - CMS reported RACs had a mere 29 percent improper payment identification rate for complex reviews in FY 2012.
 - A survey by the American Hospital Association found that nearly 60 percent of medical records reviewed by RACs in the fourth quarter of 2013 did not contain an overpayment. Hospitals reported appealing 49 percent of denials, with a 64 percent success rate.
 - According to the Office of the Inspector General, 72 percent of appealed Part A denials are eventually overturned.
- **The appeals process is broken, and providers are caught in the middle.**
 - CMS recently allowed RACs to double the number of audits. This change—and the focus on medical necessity audits—have dramatically increased the number of cases being appealed to the Administrative Law Judge (ALJ).
 - Due to the appeals process timeline, 71 percent of RAC appeals are now stuck in the appeals process. This extreme backlog has resulted in the suspension of assignment to an ALJ for at least two years.
 - Since payment for denied claims are recouped before the ALJ level, a significant amount of hospital funds are held captive for years while the hospital waits for a hearing.
 - Many hospitals simply do not have the resources to pursue an appeal on every case.

- **CMS is not paying for all medically necessary care, contrary to law.**
 - If a Medicare auditor finds that hospital care could have been provided on an outpatient basis rather than inpatient basis, Medicare is required to pay for the services provided at the outpatient rate.
 - Because RACs are allowed to audit claims over a prior three-year period, but hospitals can only rebill for services from the prior year, there is no mechanism for hospitals to rebill for claims denied during the previous two years.
 - Even when a hospital can meet timely filing deadlines, it might not recover full payment because CMS has exempted some services from outpatient payment following RAC denial of an inpatient claim.
- **RACs second-guess physicians.**
 - Medicare rules authorize physicians to determine whether a patient should be admitted to a hospital. In the rules, CMS acknowledges that an admission decision is a “complex medical judgment” that requires the professional expertise of a doctor.
 - RACs hire auditors—typically nurses and therapists—to evaluate records up to three years after a patient was treated. Auditors are not required to have clinical expertise in the area of medicine for which the patient was being treated.
 - While RACs are required to have a chief medical officer on staff, that individual oversees the functions of an entire region—17 states in region D where Arizona is located.
- **The RAC program needs better oversight.**
 - Arizona hospitals have identified a number of operational problems with the RAC performance, including non-compliance with audit decision deadlines and timely issuance of key correspondence that is needed to manage payments and appeals.
 - The high overturn rate on appeal signifies that there are chronic problems with complex audits that need to be addressed.

Audits focusing on short stay admissions are particularly troubling, especially to physicians who must make clinical decisions based on the best knowledge they have at the time. Their medical judgment is second-guessed months or even years after treatment has been provided. Denials for “short stays” must then be treated as outpatient claims, which raises concerns over (1) patient cost-sharing under Medicare Part B and (2) hospitals ability to rebill under timely filing requirements. CMS has responded to this controversy by promulgating the two-midnight policy, whereby inpatient stays spanning two midnights will generally be considered appropriate for inpatient reimbursement. Hospital stays less than two midnights will generally be considered outpatient cases, regardless of clinical severity.

Analysis

Hospitals take seriously their obligation to properly bill for the services they provide to Medicare beneficiaries and are committed to working with CMS to ensure payment accuracy. AzHHA and its members recognize the need for auditors to identify billing mistakes; however, multiple auditors conducting redundant audits, unmanageable medical record requests and inappropriate payment denials drain time and resources that could more effectively be focused on patient care. More oversight is needed by CMS of audit contractors to prevent inaccurate payment denials and to make its overall auditing function more transparent, timely and administratively practical.

CMS's two-midnight policy in part resulted from problems arising from RAC audits of short stay admissions. While well-intentioned, the policy itself has caused concern among clinicians, hospital administrators and Medicare beneficiaries. CMS has issued only minimal guidance, much of which has raised additional questions. As a result, CMS and more recently Congress have partially delayed enforcement of the two-midnight policy until March 31, 2015. In the meantime, it is clear that a more comprehensive solution is needed to address the reasonable and necessary inpatient-level services that are provided to Medicare beneficiaries whose hospital stays are not expected to span two midnights.

Our Position

AzHHA strongly supports efforts to improve the RAC and other Medicare audit programs. Specifically, we support the *Medicare Audit Improvement Act of 2013* (S. 1012/H.R. 1250). The legislation would:

- Establish a consolidated limit for medical record requests;
- Improve auditor performance by implementing financial penalties and by requiring medical necessity audits to focus on widespread payment errors;
- Improve recovery auditor transparency;
- Assure due process appeals for claims reopenings;
- Allow accurate payment for rebilled claims; and
- Require physician review for Medicare denials.

AzHHA also supports efforts to find a workable solution to address the reasonable and necessary inpatient-level services that are provided to Medicare beneficiaries whose hospital stays are not expected to span two midnights. Such an effort should include consideration of an alternative payment methodology for short inpatient stays.

AHA's Issue Papers on Regulatory Relief

H.R. 1250/S. 1012 Does Not Diminish Medicare Fraud Fighting

- If a hospital engages in fraud, that organization can – and should – be held accountable under the *False Claims Act*.
- Recovery Audit Contractors' (RACs) primary task is assessing payment accuracy – not addressing fraud. If a RAC identifies fraud, it must refer that case to a Medicare fraud-fighting entity.
- H.R. 1250/S. 1012 does not place any limits on the ability of any entity charged with fighting Medicare fraud to do so. Medicare fraud fighters are Zone Program Integrity Contractors, the Department of Health and Human Services (HHS) Office of Inspector General and the Department of Justice.

Hospitals Work Hard to Accurately Bill Medicare the First Time

- Hospitals take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries.
- Hospitals make large investments in personnel, software and compliance program checks and balances to avoid costly and time-consuming inaccuracies.
- Hospitals want to bill, and be paid, accurately the first time.

RAC Fact:

Nearly 60% of the hospital medical records reviewed by RACs are found to have no overpayment error.¹

Hospitals Need a Level Playing Field with RAC Bounty Hunters

- RACs are not impartial judges of Medicare payments. Rather, RACs prosper financially from commissions on each rejected claim.
- A single auditor can produce dozens of denials per day, while hospitals must appeal every incorrect denial through a two-or-more year, one-claim-at-a-time appeal.
- RAC auditors much later second guess the medical decisions made by physicians who examined and treated a Medicare beneficiary in a hospital.
- RACs audit services that are up to three years old, but hospitals can only rebill RAC decisions on services from the prior 12 months.

RAC Fact:

RAC auditors are typically nurses and therapists, who are paid to second guess the medical expertise of the physicians who treated Medicare beneficiaries.

RAC Appeals Are Adding Costs to an Overloaded System

- Nearly three-fourths of all appealed claims are still sitting in the appeals process.¹
- Each appeal typically requires two or more years for a final decision.
- The extreme backlog of appeals has resulted in a suspension of assignment of at least two years for appeals to the Administrative Law Judge (ALJ); wait time of at least an additional six months occur before a judge hears an appeal after assignment.

RAC Fact:

Per RACTrac, 47% of hospital denials are appealed and almost 70% of these appeals are overturned.²

H.R. 1250/S. 1012 Would Fix Many Problems with the RAC Program

- H.R. 1250/S. 1012 would correct persistent operational problems by the RACs.
- H.R. 1250/S. 1012 would correct Centers for Medicare & Medicaid Services (CMS) policies that provide hospitals with less than full payment for reasonable and necessary care.
- H.R. 1250/S. 1012 would establish manageable limits on record requests and ease the heavy administrative burden for hospitals.
- H.R. 1250/S. 1012 would require transparent reporting of RAC audit and appeals.

¹AHA RACTrac survey of 2,400+ hospitals. Quarter 3, 2013 data.

²CMS's FY 2011 Report found an overturn rate of 44% for denials that were appealed for Medicare Part A, Part B and DME.

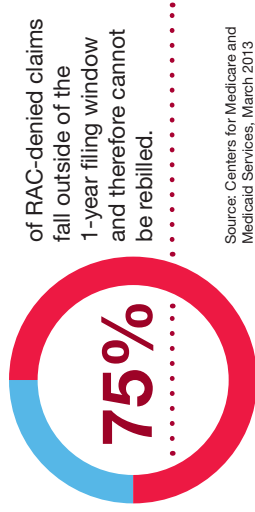
THE RAC BURDEN

How a Well-Intentioned Federal Program Has Become a Drain on Hospitals
The national Recovery Audit Contractor (RAC) program began in 2010 with the goal of ensuring accurate payments to Medicare providers. However, 5 years later, the program requires fundamental reform.

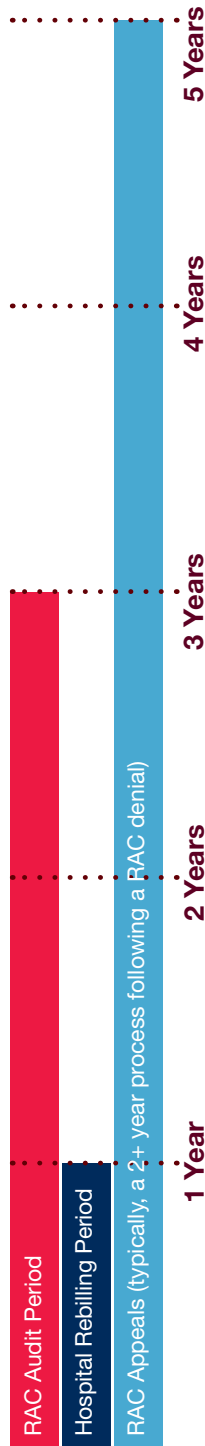
Unlawful policy prevents full payment for needed patient care.

- Many denials are for inpatient care (Part A) that was medically necessary, but RACs contend the care could have been provided in the hospital outpatient (Part B) setting.
- Medicare rules prohibit hospitals from rebilling these services for payment under Part B if they are older than 1 year, while RACs can audit medical records up to 3 years old.

This disparity costs hospitals millions and violates CMS's statutory requirement to pay for all reasonable and necessary care.



Source: Centers for Medicare and Medicaid Services, March 2013



RACs are bounty hunters paid a contingency fee based on the money clawed back from denied claims.

For each Medicare claim they deny, RACs receive a commission of

9.0-12.5%.

Due to this incentive structure, RACs frequently target high-dollar inpatient claims.

RACs are often inaccurate and inflict avoidable legal and administrative costs on hospitals.

RACs find no overpayment error with 58% of audited claims.

RAC-denied claims: 42%

Source: AHA RACTrac, November 2013



Source: Office of the Inspector General, November 2012

RACs' errors and inefficiencies force hospitals to redirect resources that could have otherwise been used for patient care.

Annual hospital spending due to RAC process:



Based on our current workload ... assignment of [hospitals'] requests for hearing to an Administrative Law Judge will be delayed for 10 to 12 months. — Office of Medicare Hearings and Appeals, August 2013

Your support of H.R. 1250/S. 1012 will help fix the flawed RAC system.



'Two-Midnight' Admission and Medical Review Criteria Policy

THE ISSUE

On Aug. 2, 2013, the Centers for Medicare & Medicaid Services (CMS) finalized its "two-midnight" policy whereby the agency will generally consider hospital admissions spanning two midnights as appropriate for payment under the inpatient prospective payment system (PPS). In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. The policy took effect Oct. 1, but CMS has

partially delayed its enforcement through Sept. 30, 2014.

CMS has issued a limited number of guidance documents to assist hospitals in implementing this policy. These documents address only narrow aspects of the policy, lack clarity and raise new questions for hospitals. As of March 1, hospitals are still waiting for additional guidance and answers from CMS, which CMS announced would be forthcoming.

AHA POSITION

Support the Two Midnight Delay Act (H.R. 3698) and the Two-Midnight Coordination and Improvement Act (S. 2082), which would require CMS to implement a new payment methodology for short inpatient stays in fiscal year 2015. In addition, we support the Senate provision that would extend CMS's partial enforcement delay through Oct. 1, 2015, or when the agency implements criteria defining short stays, whichever is first.

WHY?

- **Hospitals need more time to come into compliance with the two-midnight policy.** Even with CMS's partial delay in enforcement through Sept. 30, 2014, there has not been enough time for hospitals to adjust. While there are some positive aspects of the policy that should be retained, hospitals need more time to evaluate and change internal policies, update existing electronic medical records systems, alter work flow processes and provide extensive education to hospital staff to ensure compliance with the new policy.
- **Many questions about the two-midnight policy remain unanswered.** The Oct. 1, 2013, implementation date has passed, yet CMS has issued only minimal guidance – most of which lacks clarity and only raises new questions for hospitals. A further delay in enforcement is necessary to allow CMS to issue clear, detailed and precisely written guidance to hospitals and Medicare review contractors and to allow hospitals additional time to operationalize these provisions appropriately.
- **CMS needs to engage stakeholders to find a workable solution for short-stay patients.** Complex patient stays of less than two midnights often require the same amount of resources as stays lasting more than two midnights. CMS should begin discussions with all affected parties to develop workable solutions – including the possibility of a long-term payment alternative – to address the reasonable and necessary inpatient-level services currently provided by hospitals to Medicare beneficiaries that are not expected to span two midnights.
- **Beneficiaries are unaware of these changes and their impact.** CMS has not provided communication to beneficiaries on this policy, meaning that hospitals will be in the position of explaining a significant coverage limitation at a patient's most vulnerable time.

Continued on reverse

KEY FACTS

CMS's two-midnight policy was implemented partially in response to the growing number of Medicare beneficiaries who receive observation services for more than 48 hours. However, the decision to admit a patient as an inpatient is a complex medical judgment that involves the consideration of many factors, such as the patient's medical history and medical needs, the types of facilities available to inpatients and outpatients, the hospital's bylaws and admission policies, the relative appropriateness of treatment in each setting, patient risk of an adverse event, and other factors. Hospitals strive to base admission decisions on these clinical considerations; yet, the medical judgment of the treating physician is all too often second guessed by auditors, including Recovery Audit Contractors, months or even years after the fact. Hospitals risk loss of reimbursement, monetary damages and penalties from auditors when they admit patients for short, medically necessary, inpatient stays. On the other hand, they face criticism from patients and CMS over the perceived use of observation status as a substitute for inpatient admission.

CMS's two-midnight policy includes the following key provisions:

- **Two-midnight benchmark**, which imposes a time-based standard for payment of inpatient admissions – an inpatient admission will generally be appropriate for payment under the inpatient PPS when the beneficiary is expected to remain in the hospital for more than two midnights.
- **Two-midnight presumption**, which instructs Medicare review contractors to presume that hospital claims with lengths of stays greater than two midnights after a physician order for admission are reasonable, necessary and generally appropriate for payment under the inpatient PPS.
- **Physician order and certification requirements**, which require that an order supported by medical information, including physician admission and progress notes, must be made by a physician (or other qualified practitioner, as provided in the regulations) and present in the medical record in order for the hospital to receive payment under the inpatient PPS.
- **Inpatient PPS offset**, whereby the agency provided a 0.2 percentage point cut to inpatient payments to offset the estimated \$220 million in additional inpatient PPS expenditures it believes will be associated with the two-midnight policy.

CMS partially delayed enforcement of the two-midnight policy and will not conduct post-payment patient status reviews for claims with dates of admission from Oct. 1, 2013 through Sept. 30, 2014. However, during that time period, CMS will move forward with prepayment “Probe and Educate” audits for inpatient admissions claims. The agency will allow Medicare Administrative Contractors (MACs) to assess hospital compliance with the two-midnight policy, focusing on the admission order requirements, certification requirements and two-midnight benchmark, and deny claims that they deem as out of compliance. MACs will be required to conduct educational outreach efforts to hospitals with denied claims, including individualized phone calls, answering questions and providing pertinent education and reference materials. As of March 1, AHA is receiving reports that hospitals are beginning to receive records requests from MACs for these Probe and Educate audits.

AHA-supported bills have been introduced to delay enforcement of the two-midnight policy. Specifically, the Two Midnight Rule Delay Act (H.R. 3698) and Two-Midnight Coordination and Improvement Act (S. 2082) would require CMS to implement a new payment methodology for short inpatient stays in fiscal year 2015. In addition, S. 2082 would extend CMS's partial enforcement delay until Oct. 1, 2015, or when the agency implements criteria defining short stays, whichever is first.

Hospital Readmissions Reduction Program

THE ISSUE

The Patient Protection and Affordable Care Act (ACA) required the Centers for Medicare & Medicaid Services (CMS) to penalize hospitals for “excess” readmissions when compared to “expected” levels of readmissions beginning on Oct. 1, 2012.

In fiscal year (FY) 2013, payment penalties were based on hospital readmissions rates within 30 days for heart attack, heart failure and pneumonia. In 2015, CMS will

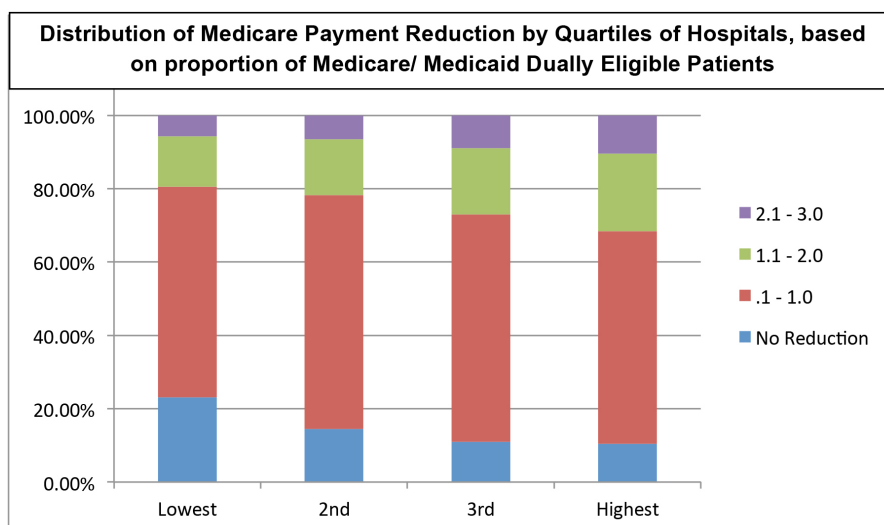
add chronic obstructive pulmonary disease and patients undergoing total hip or knee replacement. CMS is likely to add other measures in the future. AHA’s concern is that, in calculating these penalties, CMS has failed to account for the complex reasons for readmissions that are associated with communities of low socioeconomic status and has failed to exclude readmissions that are unrelated to the original admission.

AHA POSITION

America’s hospitals are focused on reducing unnecessary readmissions. However, the Hospital Readmissions Reduction Program (HRRP) is deeply flawed and must be reformed to adequately account for socioeconomic factors of communities and appropriately exclude unrelated readmissions that are not related to the initial admission.

WHY?

- **The formula fails to account for patient socioeconomic status.** A large body of research demonstrates that readmissions rates are likely to be higher for patients dually eligible for Medicare and Medicaid. One such study by Koenig and colleagues in *Health Services Research* in 2013 demonstrated this using the current measures and those to be added to the program next year. As clearly shown in the chart below, hospitals with the highest proportion of dually eligible patients constitute the lowest proportion of hospitals with no reduction and the highest proportion of hospitals with the largest deductions. Congress should require CMS to adjust the readmission measure based on patients’ dual-eligible status.



Continued on reverse

- **Safety-net hospitals are disproportionately penalized for caring for our most vulnerable patients.** Similar to the study on the previous page, a recent Kaiser Health News analysis of FY 2013 readmissions penalties showed that hospitals serving the poorest patients were not only more likely to incur a penalty, but also more likely to incur the maximum penalty.

A 1990 study by Vinson, et al, concluded that 76 percent of congestive heart failure readmissions were related to inadequacies in discharge planning, follow-up by the patients, social support for patients and patient self-management. Such factors are frequently of greater concern in economically challenged communities and outside the control of the hospital and its staff. Failing to adjust readmissions measures for socioeconomic factors takes away critical resources from the hospitals and patients that need them most.

- **The policy penalizes hospitals for unrelated admissions that occur within 30 days of the original hospitalization.**

Readmissions unrelated to the initial reason for admission should be excluded from the readmission measures.

Although the ACA requires that unrelated readmissions be excluded from the program, CMS has not fully implemented this policy. For example, a patient may be hospitalized for pneumonia, and then readmitted within 30 days for a hip fracture, which is clearly unrelated to the pneumonia. The current measures would count this readmission.

KEY FACTS

The ACA requires that inpatient prospective payment system hospitals with higher-than-expected readmissions rates will experience decreased Medicare payments for all Medicare discharges. Critical access hospitals and post-acute care providers are exempt.

Performance evaluation is based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program and reported on Hospital Compare. The base inpatient payment for hospitals with actual readmission rates higher than their Medicare-calculated expected readmission rates are reduced by an adjustment factor that is the greater of:

- A hospital-specific readmissions adjustment factor based on the number of readmitted patients in excess of the hospital's calculated expected readmission rate; or
- 0.99 in FY 2013; 0.98 in FY 2014; and 0.97 in FY 2015 and beyond.

This means the largest potential reduction for a hospital would be 1 percent in FY 2013; 2 percent in FY 2014; and 3 percent in FY 2015 and beyond. These reductions apply to all Medicare discharges. Hospitals with a small number of applicable patient cases, as determined by the Secretary of Health and Human Services, are excluded.

Beginning in FY 2015, the law allows the secretary to expand the list of conditions and the secretary has chosen to add chronic obstructive pulmonary disorder and total hip and knee replacement. The secretary is directed to seek endorsement from the National Quality Forum for all measures used to assess readmissions performance. If the problems with the program are not fixed now, they will likely create even more serious challenges for hospitals.

AzHHA's Position Paper on Rural Healthcare

Supporting the Rural Safety Net

The Issue

Rural hospitals, due to their small size, modest financial portfolio, and higher percentage of elderly and low-income patients, are particularly vulnerable to the financial risks associated with the Medicare prospective payment system (PPS). Recognizing this, Congress has established policies to protect and stabilize access-to-care for Medicare beneficiaries living in rural areas. Specifically, Congress has created the critical access hospital (CAH) designation, under which Medicare pays qualifying small rural hospitals on a reasonable cost basis. Hospitals that do not qualify as CAHs but meet sole community hospital (SCH) or small rural hospital criteria have been eligible for other payment enhancements, such as a low-volume adjustment (LVA).

AzHHA's Position

AzHHA supports the continuation of Medicare payment enhancements for rural hospitals, including the LVA, Medicare Dependent Hospital program, 101 percent of reasonable costs for CAHs, and enhancements for SCHs. We also support legislative efforts to reduce the regulatory burden on small rural hospitals and CAHs, including adopting a default standard of general supervision for outpatient therapy and removing the 96-hour physician certification requirement as a condition of payment for CAHs.

Background

The Medicare prospective payment system seeks to pay *efficient providers* the cost of furnishing healthcare services. However, certain factors beyond providers' control can affect the costs of care, which is why Congress established alternative payment programs for small rural hospitals.

Critical Access Hospitals

The *1997 Balanced Budget Act* created the CAH certification program under which Medicare would pay rural hospitals with 25 or fewer beds that meet specific location criteria 100 percent of reasonable cost. Congress enacted the program to protect small, isolated hospitals that do not have the volume necessary to absorb the financial risks associated with the PPS payment methodology. The *Medicare Modernization Act of 2003* increased reimbursement to 101 percent of reasonable cost, but this amount has been reduced by 2 percent due to Medicare sequestration cuts. Medicare currently pays CAHs 99 percent of reasonable cost.

Low-Volume Adjustment

Small rural hospitals that do not qualify for CAH designation may be eligible to receive a “low-volume adjustment.” Twelve Arizona hospitals received the adjustment in 2013, including five operated by Indian Health Services (IHS) or tribal organizations.

The *Affordable Care Act (ACA)* and subsequent legislation has temporarily improved the low-volume adjustment. Under the new policy, a low-volume hospital is defined as one that is more than 15 road miles (rather than 35 miles) from another comparable hospital and has up to 1,600 Medicare discharges (rather than 800 total discharges). An add-on payment is given to qualifying hospitals, ranging from 25 percent for hospitals with fewer than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges. The value of this adjustment cannot be overstated for Arizona’s small rural hospitals.

Sole Community Hospitals

The SCH program was created by Congress to maintain access to needed health services for Medicare beneficiaries in isolated communities. Hospitals typically qualify for SCH status by demonstrating that because of distance between hospitals (more than 35 miles), they are the sole source of hospital services available in a wide geographic area. Hospitals with SCH status presently receive payment enhancements and protections under Medicare prospective payment systems.

Analysis

Arizona’s first CAHs came online in 2002. For three years prior to this time period, Arizona’s rural hospitals were experiencing **negative** Medicare margins of **(5.6 percent)**, **(7.4 percent)** and **(9.0 percent)** respectively. It was not unusual for CAH-eligible hospitals to have negative margins in the double digits. Cost-based reimbursement helped to stabilize the financial situation of these facilities. Without the CAH program, it is quite probable that several of these community hospitals would not have survived.

Non-CAH rural hospitals continue to experience volatile Medicare margins. For 2011, seven out of 10 Arizona SCHs had negative margins, five of which exceeded **negative 10 percent**. For 2012, the average Medicare margin for rural hospitals between 25 and 49

beds was **negative 10.4 percent**. For hospitals with 50 to 99 beds, the average margin was a **negative 15.7 percent**.

Without the payment enhancements provided by the CAH, LVA and SCH programs, it is clear the financial situation for these facilities would be dire. It is critical that Congress continue to support these programs. Arizona CAHs are particularly vulnerable to proposals that would tighten the distance requirements between CAHs and other hospitals. Unlike many other states, a significant proportion of Arizona CAHs are operated by IHS and tribal organizations. Some of these facilities are located in close proximity to other CAHs or small rural hospitals operating in neighboring communities. The individual facilities serve their own communities, but also collaborate and support one another as needed. Should Congress move to change CAH mileage requirements, distances/proximity to hospitals serving unique populations (e.g., IHS or veterans' hospitals) and those providing unique services (e.g., rehabilitation or psychiatric hospitals) should be excluded from the calculation.

Rural hospitals also face tougher workforce challenges than their urban counterparts. Recent policies adopted by the Centers for Medicare & Medicaid Services have placed unreasonable hurdles on these hospitals. The most difficult of these policies are the direct supervision requirement for outpatient therapeutic services and the 96-hour physician certification requirement for CAHs. Legislation proposed last year would ease these requirements.

Our Position

AzHHA strongly supports continuation of Medicare payment enhancements for rural hospitals. Specifically, we support:

- Permanently extending the LVA and Medicare Dependent Hospital program;
- Ensuring CAHs are reimbursed 101 percent of reasonable costs; and
- Continuing enhancements for SCHs.

We also support legislative efforts to reduce the regulatory burden on small rural hospitals and CAHs, including the *Protecting Access to Rural Therapy Services Act*, which adopts a default standard of general supervision for outpatient therapy and the *Critical Access Hospital Relief Act*, which removes the 96-hour physician certification requirement as a condition of payment for CAHs.

Finally, we oppose any changes to the distance/proximity requirements for CAHs that do not take into account the special populations served by nearby hospitals (e.g., veterans or IHS/tribal) or limited services provided by them (e.g., psychiatric or rehabilitation).

AHA's Issue Papers on Rural Healthcare

THE ISSUE

Because of their size, modest assets and financial reserves, and higher percentages of Medicare patients, small and rural hospitals disproportionately rely on government payments. Medicare payment systems often fail to recognize the unique circumstances of small or rural hospitals.

Rural and Small Hospitals

Many rural hospitals are too large to qualify for critical access hospital (CAH) status, but too small to absorb the financial risk associated with prospective payment system (PPS) programs. With deficit reduction as a key goal in Washington, small and rural health care providers continue to be in jeopardy.

AHA POSITION

The AHA is focused on ensuring all hospitals have the resources they need to provide high-quality care and meet the needs of their communities. That means:

- Advocating for appropriate Medicare payments;
- Working to extend expiring Medicare provisions that help them maintain financial viability;
- Improving federal programs to account for special circumstances in rural communities; and
- Seeking adequate funding for annually appropriated rural health programs.

In addition, existing special rural payment programs – the CAH, sole community hospital (SCH), Medicare-dependent hospital (MDH), and rural referral center (RRC) programs – need to be reauthorized, updated and/or protected.

KEY PRIORITIES

Rural Legislation

The Bipartisan Budget Act of 2013 contained several provisions important to rural hospitals. The AHA continues to work to extend the law's rural extender provisions, plus several others. Key rural hospital provisions are:

- MDH program (expires March 31);
- Low-volume hospital payment adjustment (expires March 31);
- Ambulance add-on payments (expires March 31); and
- Outpatient therapy caps exception process (expires March 31). (While the AHA supports extending the outpatient therapy exception process, we oppose the expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.)

The AHA will work with Congress to:

- Extend expiring provisions;
- Allow hospitals to claim the full cost of provider taxes as allowable costs;

- Ensure CAHs are paid at least 101 percent of costs by Medicare Advantage plans;
- Ensure that the Centers for Medicare & Medicaid Services (CMS) appropriately addresses the issue of direct supervision for outpatient therapeutic services for rural hospitals and CAHs;
- Ensure rural hospitals and CAHs have adequate reimbursement for certified registered nurse anesthetist and stand-by services;
- Exempt CAHs from the Independent Payment Advisory Board;
- Exempt CAHs from the cap on outpatient therapy services;
- Provide CAHs bed size flexibility;
- Reinstate CAH necessary provider status;
- Remove unreasonable restrictions on CAHs' ability to rebuild; and
- Extend the 340B Drug Discount Program to additional hospitals and for the purchases of drugs used during inpatient hospital stays, and oppose any attempts to scale back this vital program.

Continued on reverse

Regulatory Policy Priorities

Critical Access Hospitals. Recent recommendations, if implemented through legislation, will challenge the continued viability of many CAHs and threaten beneficiaries' access to care in rural America.

- In April, President Obama released a budget outline for fiscal year (FY) 2014. The budget proposal called for substantial Medicare and Medicaid cuts over the next 10 years, including a \$16 million cut to rural programs. In addition, the administration proposed changes to payments for CAHs. Starting in FY 2014, it would reduce CAH payments from 101 percent to 100 percent of reasonable costs and eliminate the CAH designation for hospitals that are less than 10 miles away from the nearest hospital.
- The HHS Office of Inspector General (OIG) issued a 34-page report on Aug. 15 recommending, among other things, that CMS seek legislative authority to remove necessary provider CAHs' permanent exemption from the distance requirement. This recommendation would negatively impact approximately 75 percent of currently existing CAHs, which provide necessary health care services to Medicare beneficiaries who would otherwise be unable to access hospital services.

CMS has recently indicated that it will begin enforcing a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. If enforced, CAHs would be forced to eliminate these "96-hour plus" services, and the resulting financial pressure on CAHs would severely affect their ability to operate and care for beneficiaries in rural communities. The AHA supports The Critical Access Hospital Relief Act of 2014 (H.R. 3991, S. 2037), which would remove this 96-hour physician certification requirement as a condition of payment for CAHs. If passed, a physician would not be required to state that the patient will be discharged or transferred in less than 96 hours in order for the CAH to be paid on that particular claim. CAHs would continue to need to meet the other certification requirements that apply to all hospitals as well as the condition of participation requiring a 96-hour annual average length of stay.

The AHA continues to strongly advocate to maintain the current CAH program, and also for fixes to payment and administration limitations that constrain the efficiency and effectiveness of these essential health care providers.

Conditions of Participation (CoPs). In February, CMS issued a proposed rule to revise certain existing Medicare requirements for hospitals, CAHs and other providers. The AHA welcomed a number of the changes, which were partially aimed at reducing burden and eliminating obsolete regulations. We were pleased that CMS proposed to rescind the CoP requirement that hospital governing

bodies must include a member of the medical staff, and replace it with a requirement for direct consultation between hospital governing bodies and medical staffs. While many hospital governing boards already include a medical staff member, the original requirement would have been difficult to meet in some circumstances, such as where boards are elected or appointed.

However, the AHA opposes a separate CMS proposal to require each hospital to have its own distinct medical staff. This would preclude hospitals in some multi-hospital systems from sharing an integrated, unified medical staff. The AHA believes that hospital leaders and medical staffs, working together, should be able to weigh the benefits of a variety of medical staff structures and determine what framework will best enable them to provide high-quality care to patients. We will continue to urge CMS to allow hospitals to have flexibility in how medical staffs may be structured. The final rule could be released in early 2014.

The AHA also supported proposed changes for CAHs that would: (1) remove a requirement for the participation of a non-CAH staff member in the development of patient care policies, and (2) modify the requirements for the on-site presence of a doctor of medicine or osteopathy, but maintain other requirements for doctors.

Electronic Health Records (EHRs) and Meaningful Use. CMS has established confusing meaningful use rules complicated by voluminous additional guidance, as well as a challenging operational structure. In addition, the final Stage 2 rules raise the bar even higher. For PPS hospitals, CMS will assess penalties beginning in FY 2015 based on whether a hospital met meaningful use in an earlier time period. For CAHs, the penalties will be based on same-year performance.

The AHA continues to work with CMS to clarify requirements and reduce the burden of registering and attesting to meaningful use. We are especially pleased that CMS has announced a reversal of its policy and will now allow CAHs to include capital leases as allowable costs in determining their meaningful use incentive payment. CMS also will allow providers additional time in 2014 to upgrade their EHRs and transition to Stage 2.

However, we continue to be concerned about the impact of the program on small and rural providers, and believe that the EHR incentives program should close, not widen, the existing digital divide. Only a small share of hospitals have met the meaningful use requirements for Stage 1 to date – fewer than half of all hospitals, and only one-third of CAHs. In addition, a recent study published in *Health Affairs* indicated that only 5 percent of hospitals have the ability to meet Stage 2 criteria. Only CAHs that successfully attested to meaningful use in FY 2011 or FY 2012 will benefit fully from the incentives; the vast majority will come on board later and receive incentives for fewer years.



IN CRITICAL CONDITION

THE FRAGILE STATE OF CRITICAL ACCESS HOSPITALS

1,330 Critical Access Hospitals (CAHs) provide essential medical care to rural communities across 45 states. Each CAH maintains 25 or fewer beds and directly contributes an average of 204 jobs to the local economy. While their health care services have bolstered rural areas, CAHs are supported by a fragile financial foundation.



BRIDGING GAPS IN ACCESS TO CARE

CAHs' service to America's rural communities plays an important role in the nation's health care landscape.

ANNUAL SERVICES PROVIDED TO PATIENTS

8 MILLION
patients treated in CAH emergency departments.

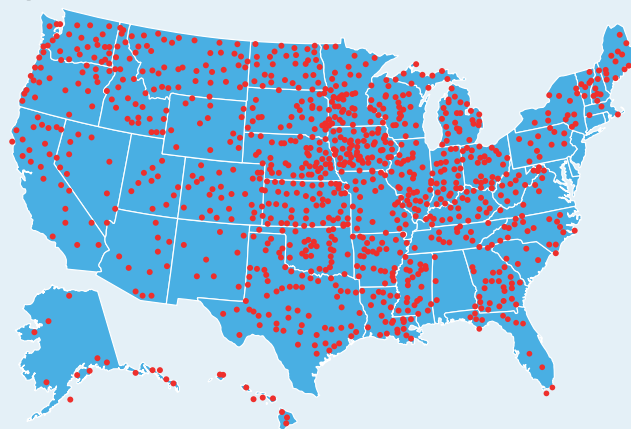
38 MILLION
outpatient visits to CAHs.

840,000
patients admitted to CAHs.

85,000
babies delivered at CAHs.



1,330 CAH LOCATIONS



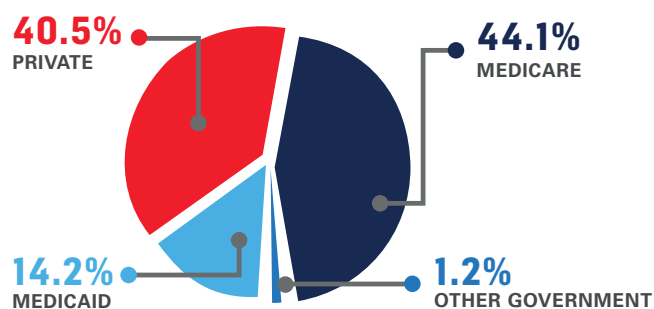
19.3% of the U.S. population resides in rural areas, as of the U.S. Census Bureau's 2010 Census.

DELICATE LIFELINES

CAHs' small size means that they can only focus on providing the most essential medical services, in contrast to higher-volume hospitals that have more resources and flexibility to offer a wider range of services. CAHs simply don't have the same economies of scale as their larger counterparts.

More than 60% of their revenue comes from government payers, such that any payment reductions to Medicare or Medicaid would have an immense impact on CAHs' ability to provide access to beneficiaries in rural communities.

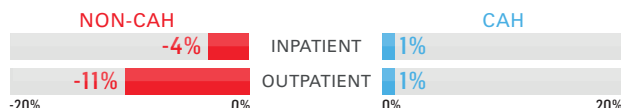
CAH PERCENTAGE OF GROSS REVENUE, BY PAYER:



A SPECIAL MEDICARE PAYMENT STRUCTURE

CAHs survive in large part due to a federal reimbursement structure that provides them funding of 1% above the cost of providing care.

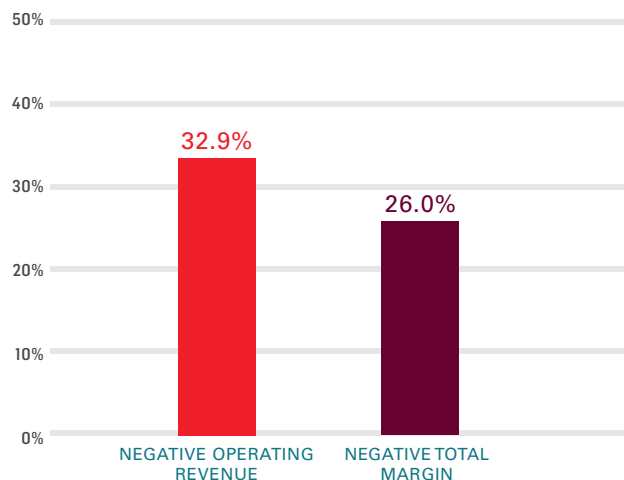
MEDICARE MARGINS, BY SERVICE AND HOSPITAL TYPE:



MANY CAHS STILL STRUGGLE

Although Medicare pays CAHs 1% above the cost of providing care, CAH revenues from other payers often don't cover costs, illustrating why adequate Medicare payments must continue in order for CAHs to be able to provide care for rural populations.

PERCENTAGE OF CAHS WITH NEGATIVE ALL-PAYER MARGINS:



CAHs make up nearly **30%** of acute care hospitals...



...but receive approximately **5%** of total Medicare payments to hospitals.



SOURCES: AMERICAN HOSPITAL ASSOCIATION | UNITED STATES CENSUS BUREAU

Data on services and payment from 2012.



Supervision of Hospital Outpatient Therapeutic Services

THE ISSUE

In the 2009 outpatient prospective payment system (PPS) final rule, the Centers for Medicare & Medicaid Services (CMS) mandated a new policy for “direct supervision” of outpatient therapeutic services that hospitals and physicians recognized as a burdensome and unnecessary policy change. CMS’s policy required that a supervising physician be physically present in the department at all times when Medicare beneficiaries receive outpatient therapeutic services.

Further, CMS characterized the change as a “restatement and clarification” of existing policy in place since 2001. As a result, hospitals and critical access hospitals (CAHs) found themselves at increased risk for unwarranted enforcement actions, particularly brought by opportunistic whistleblowers claiming that hospitals did not have appropriate direct physician supervision arrangements in place in some or all of its affected departments dating back to 2001.

Through multiple letters, meetings and other advocacy in the intervening years, the AHA and other national hospital and physician organizations have urged CMS to rescind or significantly modify the policy and to mitigate the new and inappropriate enforcement risks that its “clarification” created. At the urging of the AHA and others, CMS has since adopted several positive changes in the regulations. Specifically, the agency has:

- Delayed enforcement of the direct supervision policy through 2013 for CAHs and small and rural hospitals with fewer than 100 beds. **Please note that starting Jan. 1, 2014, CMS will permit its contractors to enforce the direct supervision policy in all hospitals and CAHs.**

- Allowed certain types of non-physician practitioners (NPPs) to provide direct supervision for hospital outpatient services, according to their state license and scope of practice and hospital- or CAH-granted privileges. This includes physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives and licensed clinical social workers;
- Modified the definition of direct supervision to remove all references to the physical boundaries within which the supervising professional must be located as long as he or she is “immediately available to furnish assistance and direction throughout the performance of the procedure;”
- Adopted a two-tiered policy for the supervision of certain “nonsurgical extended duration therapeutic services” such as observation services and various infusions and injections. This policy requires direct supervision only for the initiation of the service, followed by general supervision once the patient is medically stable; and,
- Established an independent review process that allows the Advisory Panel on Hospital Outpatient Payment ([HOP Panel](#)) to recommend, and CMS to adopt, alternate supervision levels, including general supervision, for individual hospital outpatient therapeutic services. CMS added four new members to the HOP Panel to represent CAHs and small and rural PPS hospitals. Based on recommendations made by five hospitals who presented at the HOP Panel’s 2012 meetings, CMS reduced the level of supervision for 49 outpatient therapeutic services from “direct” to “general” supervision.

AHA POSITION

The AHA is deeply disappointed that, despite our urging, CMS will move forward with enforcement of its direct supervision policy in all hospitals and CAHs as of Jan. 1, 2014. Given the shortage of medical professionals, this policy may force small and rural hospitals and CAHs to limit their hours of operation or cut services to comply with the provision, resulting in reduced access to outpatient care in communities across America. **The AHA will continue to urge Congress to provide relief from this short-sighted policy. The following important changes are included in AHA-supported legislation, the *Protecting Access to Rural Therapy Services Act of 2013* (S. 1143/H.R. 2801):**

- Adopt a default standard of “general supervision” for outpatient therapeutic services and supplement with a reasonable exceptions process with provider input to identify those specific procedures that require direct supervision;
- Ensure that for CAHs the definition of “direct supervision” is consistent with the CAH conditions of participation (CoP) that allow a physician or NPP to present within 30 minutes of being called; and
- Prohibit enforcement of CMS’s retroactive reinterpretation that the “direct supervision” requirements applied to services furnished since Jan. 1, 2001.

WHY?

- **In an environment of continuing shortages of health care professionals, particularly in rural areas, the direct supervision requirement will be difficult to implement for hospitals and CAHs, will reduce access and is clinically unnecessary.** It will require hospitals to engage more physicians and NPPs for direct supervisory coverage without a clear clinical need and create patient access problems if hospitals are forced to discontinue or limit the hours of certain outpatient services.
- **CMS's view that this policy has applied to outpatient therapeutic services furnished since 2001 opens up the entire hospital community to misplaced enforcement scrutiny, including potential recoupments and whistleblowers who can claim that a hospital did not have appropriate direct physician supervision arrangements in place in some or all of its affected departments dating back to 2001.**
- **Direct supervision is not a requirement of the Medicare hospital CoPs and, in fact, the rules contradict the CoPs for CAHs.** One CAH CoP requires a physician or NPP to be available by phone, but not necessarily physically present on the CAH campus. In order to ensure access to hospital emergency care in these otherwise underserved areas, another CAH CoP has long required only that a physician or NPP be able to arrive within 30 minutes of a request from the staff in the facility. Therefore, CAHs may meet the CoPs yet be non-compliant with direct supervision regulations.

KEY FACTS

Hospital outpatient therapeutic services have always been provided by licensed, skilled professionals under the overall direction of a physician and with the assurance of rapid assistance from a team of caregivers, including a physician, should an unforeseen event occur. While hospitals recognize the need for direct supervision for certain outpatient services that pose high risk or are very complex, CMS's policy generally applies to even the lowest risk services.

The HOP Panel. The HOP Panel is an independent review body that considers stakeholder testimony and advises CMS regarding whether it is appropriate to change the level of supervision for individual hospital outpatient therapeutic services – from direct to either general or personal supervision – so as to ensure an appropriate level of quality and safety for the delivery of patient care.

The current definitions for the three levels of supervision that are relevant to the HOP Panel are:

- **Direct supervision** means that the physician or NPP must be immediately available to furnish assistance and direction throughout the performance of the procedure. The physician or NPP is not required to be present in the room when the procedure is performed.

- **General supervision** means the procedure is furnished under the physician's or NPP's overall direction and control, but the physician's or NPP's presence is not required during the performance of the procedure.
- **Personal supervision** means a physician or NPP must be in the room during the procedure.

In the 2014 outpatient PPS final rule, CMS ended its moratorium on enforcement of the direct supervision policy for outpatient therapeutic services provided in CAHs and small and rural PPS hospitals with 100 or fewer beds. This means that CMS and its contractors are permitted to begin enforcing the direct supervision policy in all hospitals and CAHs as of Jan. 1, 2014. While the AHA will continue to urge Congress to provide relief from this policy, hospitals with an interest in this issue are strongly encouraged to consider providing testimony before the HOP Panel at its March and August meetings.



96-Hour Physician Certification Requirement for Critical Access Hospitals

BACKGROUND

There is a Medicare **condition of participation** related to length of stay for critical access hospitals (CAHs), which requires CAHs to provide acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient. There also is a separate, and distinct, **condition of payment** for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to a

hospital within 96 hours after admission to the CAH.

Although the Centers for Medicare & Medicare Services (CMS) enforces the condition of participation, the agency historically has not enforced the condition of payment. CMS recently published guidance, in relation to its new two-midnight admissions policy, that implies the agency will begin enforcing this condition of payment going forward.

AHA POSITION

AHA supports the *Critical Access Hospital Relief Act of 2014 (H.R. 3991/S. 2037)*, which would remove the 96-hour piece of the physician certification requirement as a condition of payment. CAHs would still be required to satisfy the other physician certification requirements. The condition of participation requiring CAHs to maintain a 96-hour annual average length of stay per patient also would remain in place.

WHY?

- **While CAHs typically maintain an annual average of 96 hours per patient, they offer some medical services that have standard lengths of stay greater than 96 hours.** Therefore, in those cases, the CAH will not satisfy the condition of payment because a physician will be unable to reasonably certify that the beneficiary's stay will be less than 96 hours.
- **If this condition of payment is enforced by CMS, CAHs will no longer receive payment from CMS for medical services requiring a beneficiary stay of longer than 96 hours – an untenable situation for providers and patients alike.** Medicare payments account for roughly 47 percent of total revenues for CAHs and any changes in these payments are difficult to absorb.
- **If CAHs are forced to eliminate these “96-hour plus” services, the resulting financial pressure on CAHs would severely affect their ability to operate and care for beneficiaries in rural communities.**
- **This unenforced condition of payment is in statute.** Therefore, a legislative change is required in order for it to be modified or removed.
- **CAHs play an essential, and often life-saving, role in our nation's health care landscape. It is imperative that the condition of payment be removed so that CAHs may continue to provide these important health care services to rural America.**

Expiring Medicare Provisions

THE ISSUE

Over the years, Congress has enacted several provisions to address the special challenges rural and other hospitals encounter in delivering health care services to the communities they are committed to serving. Most

recently, Congress passed the *Bipartisan Budget Act of 2013*, which contained many provisions important to hospitals. Yet a number of programs critical to hospitals will expire this year or already have expired.

AHA POSITION

These provisions are critical and must be further extended and, in some cases, made permanent.

WHY?

- These programs are of critical importance to hospitals and the patients and communities they serve. It is often difficult for hospitals to plan for community and patient needs when there is uncertainty over whether a program will continue. For these reasons, it is necessary that Congress extend these important provisions.

KEY PROVISIONS

Medicare-dependent Hospital (MDH) Program

The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. Additionally, rural residents on average tend to be older, have lower incomes and suffer from higher rates of chronic illness than their urban counterparts. This greater dependence on Medicare may make certain rural hospitals more financially vulnerable to prospective payment. To reduce this risk and support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, Congress established the MDH program in 1987. The approximately 200 MDHs are paid for inpatient services using the sum of their prospective payment system (PPS) payment rate plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. These payments allow MDHs greater financial stability and leave them better able to serve their communities. This program expires March 31.

Low-volume Adjustment

The *Patient Protection and Affordable Care Act (ACA)* improved the then low-volume adjustment for fiscal years (FYs) 2011 and 2012. For these years, a low-volume hospital was

defined as one that was more than 15 road miles (rather than 35 miles) from another comparable hospital and had up to 1,600 Medicare discharges (rather than 800 total discharges). An add-on payment was given to qualifying hospitals, ranging from 25 percent for hospitals with fewer than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges. About 500 hospitals received the low-volume adjustment in 2013.

Medicare seeks to pay efficient providers their costs of furnishing services. However, certain factors beyond providers' control can affect the costs of furnishing services. Patient volume is one such factor and is particularly relevant in small and isolated communities where providers frequently cannot achieve the economies of scale possible for their larger counterparts. Although a low-volume adjustment had existed in the inpatient PPS prior to FY 2011, the Centers for Medicare & Medicaid Services (CMS) had defined the eligibility criteria so narrowly that only two to three hospitals qualified each year. The improved low-volume adjustment in the ACA better accounts for the relationship between cost and volume, helps level the playing field for low-volume providers, and sustains and improves access to care in rural areas. This program expires March 31.

Continued on reverse

Ambulance Add-on Payments

Small patient volumes and long distances put tremendous financial strain on ambulance providers in rural areas. To help alleviate this situation and ensure access to ambulances for patients in rural areas, the *Medicare Prescription Drug Improvement and Modernization Act* increased payments by 2 percent for rural ground ambulance services and also included a super rural payment for counties in the lowest 25 percent in population density. Congress, in the *Medicare Improvements for Patients and Providers Act*, raised this adjustment to 3 percent for rural ambulance providers.

Congress appropriately decided that these additional rural payments were necessary and important because rural ambulance providers incur higher per-trip costs because of longer travel distances and fewer transports of patients. These provisions ensure that ambulance services are more appropriately reimbursed and that beneficiaries in rural and super rural areas will have access to emergency transport services. These provisions expire March 31. In addition, the law calls for the Secretary of Health and Human Services to undertake studies on ambulance costs.

Outpatient Therapy Caps

Medicare currently sets annual per beneficiary payment limits for outpatient therapy services (physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP)) provided by therapists and other eligible professionals in certain settings. The law allows for an exceptions process to the cap if the therapy is deemed medically necessary. This exceptions process has been extended numerous times in legislation.

In 2012, the *Middle Class Tax Relief and Job Creation Act* temporarily expanded the therapy cap to services provided in hospital outpatient departments (HOPDs) from Oct. 1 through Dec. 31, 2012. The *American Taxpayer Relief Act* (ATRA) continued the temporary expansion of the therapy cap to services provided in HOPDs through Dec. 31, 2013, and further extended the therapy cap exceptions process through Dec. 31, 2013. The *Bipartisan Budget Act of 2013* extended both provisions through March 31, 2014.

In addition, the ATRA required CMS to count therapy services furnished by a critical access hospital (CAH) toward the therapy cap through Dec. 31, 2013. As a result of the ATRA, in the Physician Fee Schedule final rule for calendar year 2014, CMS reassessed and reversed its longstanding interpretation of existing statute by subjecting CAHs to the therapy cap beginning Jan. 1, 2014.

While the AHA supports further extending the outpatient therapy exceptions process, we oppose expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.

Outpatient Hold-harmless Payments for Small Rural Hospitals and Sole Community Hospitals

When the outpatient PPS was implemented, Congress made certain rural hospitals with 100 or fewer beds eligible to receive an additional payment adjustment, referred to as “hold harmless” transitional outpatient payments (TOPs). “Hold harmless” TOPs were intended to ease the transition from the prior reasonable cost-based payment system to the outpatient PPS. That provision originally expired Jan. 1, 2004; however, because of concerns about the financial stability of these small rural hospitals, Congress has extended the provision every year since and has subsequently expanded it to apply to equally vulnerable sole community hospitals (SCHs). It is important to note that not every eligible hospital benefits from the hold harmless every year; instead, it is only those whose costs exceed their payments during that cost year.

Hospitals that receive TOPs already have Medicare payments that are well below their Medicare costs, with payments averaging about 82 percent of costs. With the expiration of this provision, TOPs-eligible hospitals are subject to a cut of about 16 percent to Medicare outpatient payments. With such a large gap between payments and costs, it will be difficult for these vulnerable hospitals to continue to provide access to critical outpatient services, such as emergency department services and chemotherapy. This program expired Dec. 31, 2012, for rural hospitals and SCHs with no more than 100 beds. It expired March 1, 2012, for SCHs with more than 100 beds. TOPs needs to be re-instated.