

# Advocacy Action Packet

## YOUR MISSION ON CAPITOL HILL

*Urge your legislators and their staff to:*

1. **REJECT** arbitrary **cuts to Medicare and Medicaid funding** for hospital services, and support real solutions as Congress looks for ways to reduce the nation's deficit.
2. **DELAY** the **Disproportionate Share Hospital (DSH) payment cuts** in the Patient Protection and Affordable Care Act to allow for coverage expansions to be more fully realized and better data to become available.
3. **SUPPORT** the passage of the **Medicare Audit Improvement Act of 2013**, which would improve auditor performance, increase transparency and permit hospitals to rebill denied claims without unreasonable restrictions.



## **REJECT:**

**Arbitrary cuts to Medicare and Medicaid funding for hospital services, and support real solutions as Congress looks for ways to reduce the nation's deficit.**





# THE CHALLENGE OF ACCESS: Ensuring the Care Will Be There

**For the past three years, Americans have watched** as Congress and the administration have tried to reach a consensus on how to reduce our nation's deficit.

The nation will face another fiscal flashpoint this summer as the debt limit is reached and the government's borrowing authority expires. Both parties have drawn lines in the sand with Republicans saying they are unwilling to accept further tax increases and Democrats saying that tax increases must be on the table.

**AHA View:** Hospital leaders understand the fiscal challenges our nation faces. But additional cuts to Medicare and Medicaid funding for hospital services would mean longer wait times for care; fewer doctors, nurses and other caregivers; and less patient access to the latest treatments and technology. The time is now to work together toward long-term solutions that will set these programs on a path toward future sustainability.

## THE CHALLENGE OF MAINTAINING ACCESS

Every day, hospital leaders face tough challenges to ensure patients continue to have timely access to essential services.

Among the most-pressing challenges:

- the **high cost of the latest technology**, equipment, devices and pharmaceuticals;
- the struggle to **attract and train** enough doctors, nurses and other caregivers;
- meeting the needs of the growing number of seniors and other patients with **multiple chronic illnesses**;
- **underpayment** from government health programs that shifts costs to employers and other patients;
- providing care for the **uninsured** and patients with **inadequate health coverage**; and
- complying with **increasing regulatory and payer requirements**.

Hospitals have absorbed more than \$250 billion in reductions since 2010, including \$14 billion in the recently passed *American Taxpayer Relief Act of 2012*. And they are facing additional reductions as a result of the *Budget Control Act's* sequestration. If federal and cash-strapped state governments further reduce payments, hospitals will face even greater challenges.

## WHAT HOSPITALS ARE DOING

Even as hospitals grapple with these challenges, they are working to make health care more affordable through innovations in care delivery focused on improving population health, increasing the quality and efficacy of care, and better managing transitions across the care continuum.

For example, hospital leaders are forming partnerships with physicians and other providers to better coordinate care and jointly engage in performance improvement initiatives. They also are strategically investing in technology such as electronic health records to improve care and efficiency.



# HEALTHY SOLUTIONS, NOT HARMFUL CUTS

We need real long-term solutions to strengthen our nation's health care system, not arbitrary cuts that undermine hospitals' ability to care.

The following harmful proposals were considered by lawmakers as they debated ways to reduce the deficit. They were ultimately rejected, but have some support and will almost surely be considered as offsets in the next round of deficit reduction talks. They include:

- cuts to payments for **evaluation and management services** and certain other procedures identified by the Medicare Payment Advisory Commission (MedPAC) provided in hospital outpatient departments;
- reductions to payments for **graduate medical education**;
- additional across-the-board cuts to Medicare inpatient hospital rates through the use of **coding adjustments**;
- restrictions on **Medicaid provider assessments**;
- payment reductions to **rural hospital programs**, including **critical access hospitals**; and
- reductions in payments to hospitals for **assistance to low-income Medicare beneficiaries** (bad debt).

More on each of these changes is outlined in the factsheets that follow.

In addition, the hospital field remains concerned about the 2 percent sequester of Medicare payments that went into effect April 1. As lawmakers consider ways to mitigate the sequester's impact or do away with the sequester entirely, we urge them to:

- include the Medicare cuts in any framework to mitigate or eliminate the sequester; and
- ensure that cuts to Medicare or Medicaid payments to providers are not used as offsets.

We also are concerned that the coverage targets set forth by the *Patient Protection and Affordable Care Act* (ACA) will not be achieved now that the law's Medicaid expansion is optional for states. We urge lawmakers to revisit cuts to payments for hospital care contained in the ACA, particularly the Disproportionate Share Hospital (DSH) payments, if the envisioned levels of coverage do not materialize.

We need real solutions, not the further ratcheting of hospital payments. Alternatives to cutting payments for hospital services to consider include:

- **Develop programs** to coordinate care for individuals eligible for both Medicare and Medicaid
- **Eliminate barriers** to developing integrated care models
- **Reduce Medicare costs** by changing cost-sharing structures for Parts A and B
- Increase the **eligibility age for Medicare** now that other coverage options are available to those individuals
- Modernize the **Medicaid long-term care benefit**
- Enact **medical liability reform**
- Reform **Medigap**

Our patients and communities depend on us, and the care we provide, to be there ... today and tomorrow.



# Outpatient Evaluation & Management Services

## THE ISSUE

**Congress is considering a 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.** For example, for a visit coded as 99201, the physician would receive the standard amount for the service

in the hospital setting (\$25.86). The hospital would receive the difference between the physician payment in the office (\$43.89) and the physician payment in the hospital, or  $\$43.89 - \$25.86 = \$18.03$ .

This would reduce the hospital payment between 65 percent and 80 percent for 10 of the most common outpatient hospital services. This proposal is estimated to reduce Medicare spending by \$900 million per year and \$9 billion over 10 years.

### Impact of Cutting Hospital Evaluation and Management Services by Code: Medicare CY 2013 Payments for Visit Services

CPT code	A	B	C	D	Hospital Payment Cut Per Visit	
	Doctor payment in office (CY 2013)	Doctor payment in hospital (CY 2013)	Current Hospital Payment (CY 2013)	New Hospital Payment (A-B=D)	Dollars	Percent
99201	\$43.89	\$25.86	\$56.77	\$18.03	(\$38.74)	-68%
99202	\$74.51	\$48.99	\$73.68	\$25.52	(\$48.16)	-65%
99203	\$107.85	\$74.85	\$96.96	\$33.00	(\$63.96)	-66%
99204	\$164.67	\$127.93	\$128.48	\$36.74	(\$91.74)	-71%
99205	\$203.80	\$164.33	\$175.79	\$39.47	(\$136.32)	-78%
99211	\$20.41	\$8.85	\$56.77	\$11.57	(\$45.20)	-80%
99212	\$43.89	\$24.50	\$73.68	\$19.39	(\$54.29)	-74%
99213	\$72.47	\$49.67	\$73.68	\$22.80	(\$50.88)	-69%
99214	\$106.49	\$76.55	\$96.96	\$29.94	(\$67.02)	-69%
99215	\$142.90	\$107.85	\$128.48	\$35.04	(\$93.44)	-73%

## AHA POSITION

The AHA strongly opposes legislation implementing MedPAC’s recommendation to equalize Medicare payment rates for E/M services between HOPDs and physician office settings 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.

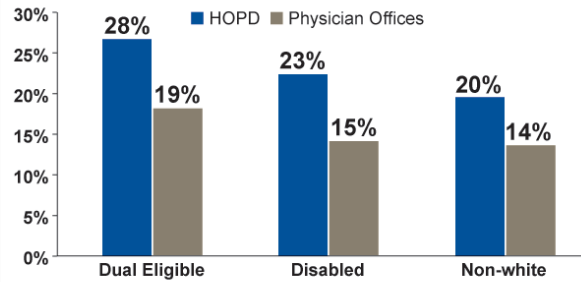
## WHY?

- **Hospitals lose money treating Medicare patients in HOPDs.** According to MedPAC’s March 2013 report, Medicare margins are negative 11 percent for outpatient services. Additional cuts to HOPDs threaten beneficiary access to these services.
- **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 that are not otherwise available in the community, 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.

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### Hospital outpatient departments serve a higher mix of vulnerable populations

Percent of Visits by Selected Patient Demographic Characteristics, HOPD vs. Physician Offices, 2009



Source: Data prepared by the Moran Company based on 5% Carrier and Denominator Claims Record 2009 data. January 6, 2009

- **Patients who are too sick for physician offices are treated in the HOPD.** 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.**
- **Hospitals are on stand-by 24/7/365.** This policy inappropriately ignores the intrinsically higher costs of providing care in a hospital setting that's open 24 hours a day, 7 days a week, 365 days a year. All those 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 have on major teaching hospitals and public hospitals. 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. These are vital safety-net providers of outpatient services, providing primary care and specialty services in clinics that serve significant numbers of low-income patients. These services are not commonly offered by free-standing physician practices.
- **Hospitals have more comprehensive licensing, accreditation and regulatory requirements.** HOPDs must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements than do free-standing physician offices.
- **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 payments.** 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.

# 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. This would cut hospital payments by 2.7 percent, or \$900 million, in one year.** This proposal reflects recent Medicare Payment Advisory Commission (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.

Unlike the E/M proposal, MedPAC has not yet formally recommended this policy amid stakeholder and commissioner concerns that such steep payment cuts

could have unintended consequences for patient access to care and hospitals’ ability to continue to provide emergency standby services.

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 results in steep cuts at the service level. For instance, under this policy, the hospital’s payment for a level II echocardiogram without contrast (APC 0269) would drop from \$387.13, the average amount currently paid under the outpatient prospective payment system (OPPS), to \$127.29 – a 67 percent reduction. This one service accounts for more than a quarter of the projected savings.

If this expanded site-neutral policy were combined with the \$900 million in E/M cuts also being considered by Congress, these payment policies would decrease hospital outpatient revenues by 5.4 percent, or \$1.8 billion, per year. As a result, they would further reduce Medicare outpatient margins from negative 11 percent in 2011 to negative 15 percent, all else being equal.

## AHA POSITION

**The AHA strongly opposes legislation that would reduce Medicare payment rates for these 66 APCs to a residual amount of the Physician Fee Schedule payment rate or to the rate paid in Ambulatory Surgery Centers (ASCs).**

**Impact of Cutting Certain HOPD Services by Code: Medicare CY 2013 Payments for a Sample of HOPD Services**

APC	Description	Current Average Hospital Payment for APC	Average Hospital Payment for APC if Paid at the Residual PFS Amount	Percent Change in Hospital Payment for APC	Aggregate Cut in Hospital Payment for APC if Paid at the Residual PFS Amount
0269	Level II Echocardiogram Without Contrast	\$387.13	\$127.29	-67%	\$276.8 million
0207	Level III Nerve Injections	\$561.94	\$348.31	-38%	\$150.0 million
0209	Level II Extended EEG, Sleep, and Cardiovascular Studies	\$788.07	\$533.92	-32%	\$82.7 million
0238	Level I Repair and Plastic Eye Procedures	\$241.11	\$41.38	-83%	\$13.0 million
0365	Level II Audiometry	\$91.18	\$6.96	-92%	\$6.9 million
0382	Level II Neuropsychological Testing	\$182.82	\$25.87	-86%	\$1.9 million

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While this 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 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.

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:** The provision of 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 an essential component 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 \$41 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 March 2013 report, Medicare margins are negative 11 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 care for low-income patients and services for patients with multiple chronic conditions provided in critical access hospitals.
- 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.
- Patients who are too sick for physician offices 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, 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 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."
- The Medicare payment systems for physicians and HOPDs are complex and fundamentally different, with many moving parts. Practically speaking this makes the application of MedPAC's site-neutral policy unstable, with any number of small technical and methodological decisions changing the outcome significantly. Basing hospital payments on such a volatile methodology could have unintended consequences.



## Graduate Medical Education

### 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. Recently, 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.** They would limit the ability of teaching hospitals to offer state-of-the-art clinical and educational experiences. The AHA opposes any cuts to GME funding, which would have a significant impact on teaching hospitals and the beneficiaries and communities they serve.
- **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 to 32 million uninsured 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).

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## 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.

## 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 last year 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 4.7 percent in 2010 to roughly negative 5.8 percent in 2011 and projects they will decline further by 2013. In FY 2009, 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.

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- **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 final rule and should not implement it at a future time.

## 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 by avoiding additional provider payment cuts. Some policymakers have called for restricting states' ability to use this program. 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 finance a portion of their Medicaid spending by imposing assessments on health care providers who are paid by the Medicaid program. 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 95 cents of every dollar spent treating Medicaid patients. Changes to the provider assessment program would further exacerbate this problem.
- **Currently, 69 million low-income Americans rely on the Medicaid program to provide access to health care. With the implementation of the *Patient Protection and Affordable Care Act (ACA)*, up to 12 million more people may be enrolled in Medicaid beginning in 2014 (based on February 2013 Congressional Budget Office estimates).** Any reduction or elimination of Medicaid provider assessments would be on top of Medicaid cuts scheduled to take effect.

### 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 to 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

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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 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 reform process that ensures the nation meets its obligation to care for the neediest of our society.

## Rural or Small Hospitals

### THE ISSUE

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

Recently, Congress passed the *American Taxpayer Relief Act of 2012*, which contained many provisions important to rural hospitals and beneficiaries. The AHA is working to extend beyond 2013 the law's rural extender provisions, plus several others. Key rural hospital provisions are:

- MDH program (expires Sept. 30);
- Low-volume hospital payment adjustment (expires Sept. 30);
- Ambulance add-on payments (expires Dec. 31); and
- Outpatient hold harmless payments (expired Dec. 31, 2012, for SCHs with more than 100 beds, it expired March 1, 2012).

#### 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;

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- Exempt CAHs from the Independent Payment Advisory Board;
- Provide small, rural hospitals with cost-based reimbursement for outpatient laboratory services and ambulance 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.

## FY 2014 Federal Budget

In April 2013, President Obama released a budget outline for fiscal year (FY) 2014. The outline, which was similar to a proposal the White House released in 2012, called for cutting Medicare by about \$374 billion and Medicaid by \$18.9 billion over 10 years. This budget proposal, as well as other deficit and spending reduction bills, would put rural hospitals at risk of cuts in several areas. The proposed cuts include:

- **Rural hospitals.** The administration proposed changes to payments for rural providers. Starting in FY 2014, it would reduce CAH payments from 101 percent to 100 percent of reasonable costs. In addition, effective in FY 2014, it would eliminate the CAH designation for hospitals that are less than 10 miles from the nearest hospital. Together, the administration estimates these rural proposals would save approximately \$2 billion over 10 years.
- **Rural health programs.** Rural health programs such as the Medicare Rural Hospital Flexibility Grant Program, Rural Health Outreach and Network Development, State Offices of Rural Health, Rural Telehealth, Rural Policy Development and other health care programs are vital to ensuring that needed services remain available in America's rural communities. The president's FY 2014 budget proposed a \$16 million cut to rural programs.

## Regulatory Policy Priorities

**Direct supervision.** For the past four years, CMS has modified its policies related to the "direct supervision" of outpatient therapeutic services, threatening to magnify physician shortage problems. By 2013, at the AHA's urging, CMS adopted several positive changes to the regulations. Specifically, the agency:

- Delayed enforcement of the direct supervision policy through calendar year (CY) 2013 for CAHs and small and rural hospitals with fewer than 100 beds;
- Allowed qualified non-physician practitioners to provide direct, general and personal supervision for most outpatient services;
- Modified the definition of direct supervision to remove all references to the physical boundaries within which the supervising practitioner must be located as long as he or she is "immediately available to furnish assistance and direction throughout the performance of the procedure;" and
- Established a process for independent review of alternate supervision levels using the Advisory Panel on Hospital Outpatient Payments.

**While we are pleased with this increased flexibility, the AHA remains concerned that hospitals and CAHs will have difficulty implementing these requirements. We continue to disagree with CMS's repeated assertion that it has required direct supervision of outpatient therapeutic services since 2001.** The AHA continues to work with CMS and Congress to make additional fundamental changes to the supervision policy. Among these, we urge the agency to adopt a default standard of "general supervision" for outpatient therapeutic services, indicating that these procedures should be performed under the physician's overall direction and control, but the physician's presence should not be required during the performance of the procedure. In addition, we urge CMS to develop a reasonable exceptions process with provider input to identify those specific procedures that require direct supervision.

**Conditions of Participation (CoPs).** In February 2013, CMS issued a proposed rule to revise certain existing Medicare requirements for hospitals, CAHs and other providers. AHA welcomed a number of the changes, which were partially aimed at reducing burden

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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, 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. 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.

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. 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.



## 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 60 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 55 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.

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## 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) – \$11,170 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 also 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 are 2.5 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 \$1,250 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
<b>Total</b>	<b>\$27,167</b>	<b>\$3,434</b>

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.

An 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 they have a deductible and copayment and that they will be billed when Medicare pays the hospital;
2. The patient receives an explanation of benefits from Medicare, which informs them of their 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.



## The 340B Drug Pricing Program

### THE ISSUE

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 that pharmaceutical manufacturers supply their products to state Medicaid programs at the manufacturer's "best price" – that is, the lowest price offered to other purchasers. 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 of the *Public Health Service Act* requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to taxpayer-supported health care facilities that care for uninsured and low-income people. Covered entities include community health centers, children's hospitals, hemophilia treatment centers, 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. HRSA states that the savings can be used to stretch scarce federal resources to reduce the price of pharmaceuticals for patients, expand services offered to patients and provide services to more patients.

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.

### AHA POSITION

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

**The AHA opposes efforts to scale back the 340B program.**

**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.**

**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.**

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## 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) 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 to allow time for stakeholders to make the necessary changes. HRSA, however, said it would not accept additional extensions beyond Aug. 7.

HRSA also is finalizing a regulation that implements the orphan drug exclusion for RRCs, CAHs and free-standing cancer hospitals. The rule, awaiting final approval, includes an important restriction to the orphan drug exclusion that allows RRCs and CAHs to purchase orphan drugs as long as these drugs are not used to treat rare conditions or diseases. AHA supports HRSA’s limitation on 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 Reference Center	≥8%	No	Yes

\*Source Apexus and HRSA, 2013



# Hospital Readmissions Reduction Program

## THE ISSUE

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

This penalty is a maximum of 1 percent of Medicare base payments in fiscal year (FY) 2013, increasing to 3 percent in FY 2015 and beyond. In FY 2013, payment penalties are based on hospital readmissions rates within 30 days for heart attack, heart failure and pneumonia.

## 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: correct the flawed payment formula; adequately account for socioeconomic factors; and appropriately exclude unrelated readmissions from the penalty.**

## WHY?

- **The formula penalizes more hospitals than Congress intended.** Only a small proportion of hospitals score as “worse than expected” on readmissions on CMS’s *Hospital Compare* website. However, two-thirds of hospitals in the HRRP received penalties in FY 2013.
- **The size of the payment penalty is excessive.** The Medicare Payment Advisory Commission (MedPAC) determined that the flawed formula’s multiplier effect penalizes hospitals approximately five times more than they were paid for those excess readmissions.
- **The formula punishes hospitals for making improvements.** MedPAC finds that the payment penalty is inversely related to the national readmissions rate for each condition. Thus, as readmission rates drop across the nation, the magnitude of the penalty grows. This threatens the goal of the program – real reduction in readmissions that mean better care for patients at lower cost.
- **The formula fails to account for patient socioeconomic status.** A large body of research demonstrates that readmissions rates are likely to be higher for non-white patients, and for patients dually eligible for Medicare and Medicaid. Congress should require CMS to adjust the readmission measure based on patients’ dual-eligible status.
- **Safety-net hospitals are disproportionately penalized for caring for our most vulnerable patients.** Those hospitals that care for the most economically disadvantaged patients receive greater readmission penalties. 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. Failing to adjust readmissions measures for socioeconomic factors – which are outside the control of hospitals – takes away critical resources from the hospitals and patients that need them most.
- **The policy penalizes hospitals for readmissions beyond their control.** 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.

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## KEY FACTS

The ACA requires that beginning in FY 2013, 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 will be 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. This reduction will 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 to include chronic obstructive pulmonary disorder and several cardiac and vascular surgical procedures, as well as any other condition or procedure the secretary chooses. The secretary is directed to seek endorsement from the National Quality Forum for all measures used to assess readmissions performance. However, the secretary has the discretion to proceed without receiving endorsement. If the problems with the program are not fixed now, they will likely create even worse challenges for hospitals and the patients they serve.

In addition, the law directs the secretary to calculate and report all-payer readmission rates for the conditions selected for the readmissions financial penalties program, based on all-payer data submitted by hospitals. No timeline is provided as to when this reporting should begin or when the all-payer data should be submitted.

## Post-acute Care Providers

### THE ISSUE

In recent years, post-acute care providers have faced scrutiny from Congress that has resulted in substantial payment cuts. Regulatory and statutory payment reductions and restrictions have been considerable for all four post-acute care sectors – long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF) and home health (HH) providers. *The Patient Protection and Affordable Care Act of 2010* (ACA) included productivity offsets and other reductions to updates, quality reporting requirements and significant HH changes. Additionally, major regulatory tightening by the Centers for Medicare & Medicaid Services (CMS) of the post-acute payment system has included coding and documentation offsets, rebasing and significant operational changes.

Most recently, the Medicare Payment Advisory

Commission (MedPAC) discussed research on payment reform approaches to eliminate the LTCH payment system and to pay for all LTCH services through the inpatient prospective payment system (PPS). This research includes developing a new category of patients – chronically critically ill (CCI) patients – who would be eligible for special payments in the inpatient PPS. The AHA is very concerned about proposals such as these, which promote severe and arbitrary changes while lacking a strong policy rationale.

In addition, the president's fiscal year (FY) 2014 budget included a \$79.04 billion cut to post-acute care providers by adjusting Medicare payment updates for SNFs, LTCHs, IRFs and HH. The budget also included lowering IRF reimbursement for selected patients to a SNF-level payment, and raising the current IRF "60% Rule" threshold.

### AHA POSITION

**Reject further reductions to post-acute services for beneficiaries who need the unique care provided in each setting.**

### WHY?

**It is excessive and unjustified to pile additional payment cuts onto already substantial reductions while comprehensive efforts are under way to identify the best approach to comprehensively re-tool the delivery system.** Current policies in the ACA and other CMS regulations already are reducing Medicare payments to post-acute care providers. Additional cuts could further exacerbate the financial pressures and limit patient access to needed post-acute care services.

**The administration's latest proposals overlook clear distinctions between SNF and IRF patients and services, as mandated and documented by CMS\*.** As a result of tougher Medicare standards, IRF case mix has increased and the number of IRF patients has dropped by 140,000 cases annually since 2004. Medicare payments to IRFs in recent years have been virtually flat, and IRF Medicare margins have declined almost each year since 2003.

**Instead of new and arbitrary across-the-board cuts to post-acute care, Congress should first allow the ACA provisions that reform the delivery of post-acute services to be developed – a complex process that requires testing in the real world – and implemented.**

\*CMS's SNF PPS Final Rule for FY 2012, Published May 2011 in the *Federal Register*.

## 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 *American Taxpayer Relief Act of 2012 (ATRA)*, 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 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 Sept. 30.

#### Low-volume Adjustment

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

one that is more than 15 road miles (rather than 35 miles) from another comparable hospital and has up to 1,600 Medicare discharges (rather than 800 total discharges). An add-on payment will be given to qualifying hospitals, ranging from 25 percent for hospitals with fewer than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges. About 500 hospitals are currently receiving the low-volume adjustment.

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 Sept. 30.

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### **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* (MMA) 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 Dec. 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* (MCTRJCA) temporarily expanded the therapy cap to services provided in hospital outpatient departments (HOPDs) from Oct. 1 through Dec. 31, 2012.

The ATRA further extends the therapy cap exceptions process through Dec. 31, 2013, and continues the temporary expansion

of the therapy cap to services provided in HOPDs through Dec. 31, 2013. In addition, the ATRA requires temporary application of the therapy cap to outpatient therapy services provided in critical access hospitals (CAHs) through Dec. 31, 2013.

While the AHA supports extending the outpatient therapy exceptions process, we oppose the temporary 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 their 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.



## **DELAY:**

The Disproportionate Share Hospital (DSH) cuts in the *Patient Protection and Affordable Care Act* to allow for coverage expansions to be more fully realized and better data to become available.



## Medicaid and Medicare DSH

### THE ISSUE

**The Medicaid and Medicare Disproportionate Share Hospital (DSH) programs have, since their inception in the early 1980s, provided vital financial support to hospitals that serve the nation's most vulnerable populations – Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured.** Because the *Patient Protection and Affordable Care Act (ACA)* was estimated to expand public and private health care coverage to 32 million more Americans by 2019, Congress

deemed it appropriate to cut both Medicaid and Medicare DSH payments to hospitals. Specifically, the ACA reduces Medicaid DSH payments by \$14.1 billion from fiscal year (FY) 2014 through 2019, and Medicare DSH payments by \$22.1 billion from FY 2014-2019. The ACA also calls for targeting DSH funds to hospitals treating large numbers of uninsured. In addition, with the uncertainty of state governments' decision on Medicaid expansion, the promise of health care coverage improvements may not be realized for some years to come.

### AHA POSITION

**Delay DSH cuts to allow for coverage expansions to be more fully realized and better data to become available.**

### WHY?

- **The Supreme Court decision will result in fewer covered individuals.** The Court's 2012 decision ruled that the federal government could not force states to expand their Medicaid programs or risk losing all of their Medicaid funding. As of March 2013, 25 governors supported expanding their Medicaid programs. As a result, according to recent Congressional Budget Office (CBO) projections, the ACA will expand coverage to only 27 million – rather than 32 million – individuals.
- **The ability for individuals to obtain coverage under the insurance exchange market places is uncertain.** Much depends on the interoperability of information systems to determine eligibility for subsidies, verification of income through the federal information hub, and determination of Medicaid eligibility as well as successful outreach enrollment programs. More than half of the states' new insurance marketplaces will be operated as federal exchanges. Very little is known, at this point, about how these exchanges will operate and how they will interface with the state insurance markets and state Medicaid programs. In addition, a number of related rules still have yet to be finalized, and one of the biggest open questions is exactly how the federally facilitated exchanges will operate.
- **DSH redistributions will be based on unreliable data.** For Medicaid DSH, the Centers for Medicare & Medicaid Services (CMS) is planning to consider the Medicaid DSH audit data in distributing funds. However, many are concerned that the audit data accurately reflect neither the number of uninsured a hospital serves nor the amount of its Medicaid shortfall. For Medicare DSH, CMS is planning to use the cost report form S-10 to distribute funds. However, these data are widely acknowledged to be inaccurate, due to poorly written instructions and a lack of hospital experience in completing the form.

Continued on reverse

## KEY FACTS

Even under the current levels of DSH funding, hospital costs for providing care to Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured are not fully met. Medicaid, on average, covers only 95 cents of every dollar spent treating Medicaid patients, while Medicare on average covers only 91 cents of every dollar treating Medicare patients. And in 2011 hospitals provided \$41.1 billion of uncompensated care.

### Medicaid ACA DSH Facts

For Medicaid, the ACA instructed the Department of Health and Human Services (HHS) secretary to consider how the reductions should be allocated across the states. The secretary must give consideration to states based on three existing categories: high-DSH states; low-DSH states; or 1115 waiver expansion states. The ACA instructed the secretary to impose a “smaller percentage reduction” on low-DSH states. In addition, the secretary must take into consideration two factors when establishing the methodology for distributing DSH payment reductions: a state’s percentage of remaining uninsured; and whether a state targets DSH payments to hospitals serving a high volume of Medicaid inpatients and hospitals that have high levels of uncompensated care (excluding bad debt).

It is expected that CMS will rely on data drawn from each states’ Medicaid DSH auditing report. These reporting and auditing requirements, which have governed the program since 2009, examine whether state Medicaid programs DSH payments are accurately calculated. CMS will not act on audit findings until the 2014 audits are complete to give states a period of time to transition to these audit and reporting requirements. In addition, CMS issued a proposed rule in 2012 that addresses issues raised by AHA and its hospital members regarding the definition of hospital uncompensated care. The proposed rule allows unreimbursed costs for those individuals with minimal health care coverage. It also clarifies that all costs incurred in providing hospital services to Medicaid patients should be counted in the determination of the hospital-specific DSH limit. These important regulatory Medicaid DSH policy changes have not been finalized. The AHA has concerns that CMS will rely on the Medicaid DSH audit data to develop the methodology to reduce DSH payments, even though the audit data is considered to not be complete and not reflective of a hospital uncompensated care costs.

### Medicare ACA DSH Facts

For the Medicare DSH reductions, payments will initially be reduced to 25 percent of what hospitals would have received under the current formula. The basic elements of the Medicare diagnosis-related group (DRG) program – the designation criteria, the payment calculation methodology and the application of payment to the DRG – remain. Then, a majority of the savings generated by this change will be used to supply a new pool of funds for Medicare DSH hospitals. The size of the new DSH pool will be based on the decrease in the non-elderly uninsured. Medicare DSH hospitals will receive additional payments from the new DSH pool based on their share of national uncompensated care for all Medicare DSH hospitals.

To implement this new policy, CMS will have to make two critical policy decisions: how to measure the change in the percentage of uninsured; and how to define uncompensated care. The agency will set forth its proposals in the FY 2014 inpatient prospective payment system (PPS) rule.

Regarding the change in the percentage of uninsured, the ACA specifies that for FYs 2014 through 2017, the percentage of uninsured in 2013 will be determined using the most recent estimate from the CBO before the Congress passed the ACA. For FYs 2018 and after, the percentage of uninsured will be based on actual data (rather than estimates) from the Census Bureau or another source that CMS determines is appropriate. However, the law is less prescriptive on how CMS will determine the percentage of the under-65 population that is uninsured in the most recent period. Many believe CMS will use estimates of the uninsured from the CBO, which are now significantly higher than when the ACA was passed.

Regarding the definition of uncompensated care, CMS will propose to use Worksheet S-10 from the hospital cost report, as it is the only national data source available that contains information on hospital uncompensated care. However, historically, the S-10 data have not been used for payment purposes. As a result, many hospitals did not complete the form, and data from those that did often appear to be incomplete. Recently though, the S-10 data are starting to be used for payment, under both the electronic health record incentive program and, of course, the Medicare DSH program. While this should lead to improvements in data accuracy and consistency, hospitals’ FY 2014 DSH payments will, at least on an interim basis, likely be based on S-10 data from their most recent cost reports from FY 2011 or 2012, which may still be unreliable and inconsistent.



## **SUPPORT:**

Passage of the *Medicare Audit Improvement Act of 2013*, which would improve auditor performance, increase transparency and permit hospitals to rebill denied claims without unreasonable restrictions.



## H.R. 1250 Does Not Diminish Medicare Fraud Fighting

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- 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 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

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- 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:**

**Two-thirds of the hospital medical records reviewed by RACs are found to have no error.<sup>1</sup>**

## 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

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- Nearly three-fourths of all appealed claims are still sitting in the appeals process.<sup>1</sup>
- Each appeal typically requires two years for a final decision.

**RAC Fact:**

**Per RACTrac, 40% of hospital denials are appealed and 72% of these appeals are overturned.<sup>2</sup>**

## H.R. 1250 Would Fix Many Problems with the RAC Program

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- H.R. 1250 would correct persistent operational problems by the RACs.
- H.R. 1250 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 would establish manageable limits on record requests and ease the heavy administrative burden for hospitals.
- H.R. 1250 would require transparent reporting of RAC audit and appeals.

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<sup>1</sup>AHA RACTrac survey of 2,300+ hospitals. Quarter 4, 2012 data.

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



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