American Hospital Association

The AHA's 2006 Advocacy Agenda

In today's world, a modernized hospital is a necessity … serving as the health care safety net, and integral to the health and economic survival of the community it serves. The very special people who work in hospitals provide compassion, care and curing, 24 hours a day, every day of the year. The American Hospital Association's Advocacy Agenda for 2006 is designed to:

Protect Care for Patients and Communities by making sure the women and men of America's hospitals have the resources they need to provide patients the right care, at the right time and in the right place.

Strengthen the Bond between hospitals and the communities they serve.

Help People Get Care by making health care more available and affordable for those in need.

Protect Care for Patients and Communities

- **Fight proposed cuts to Medicare and Medicaid funding.**

  As the federal deficit continues to grow, Medicare and Medicaid funding are once again the targets of proposed budget cuts. In fact, the Administration has proposed almost $36 billion in cuts to Medicare ($19 billion from hospitals) and $13.6 billion in cuts to Medicaid ($5.8 from hospitals) over five years. We'll fight hard against those cuts, because more than 80 million Americans who are covered by Medicare and Medicaid depend on their local hospitals to provide the vital care they need. To keep this commitment, hospitals must have adequate resources. But these government programs already pay well below the cost of caring for their beneficiaries. In 2004, about 7 of every 10 hospitals lost money serving Medicare patients. At the same time, hospitals are serving more and more people who need hospital services, the baby boom generation is on the cusp of retirement, and up-to-date drugs and technologies, a qualified

workforce in adequate numbers, and updates to aging facilities require significant investment. This effort includes working to change an unfortunate Centers for Medicare & Medicaid Services (CMS) proposed ruling that alters the definition of "uncompensated care" under the Medicaid Disproportionate Share Hospital program in a way that threatens to dramatically cut Medicaid's support for hospitals who take care of our nation's most needy patients.

(See the attachment for a select breakdown of the President's budget as it relates to health care.)

- **Make permanent a ban on physician self-referral to new limited-service providers**

When a moratorium originally imposed by Congress expired in June 2005, CMS imposed a suspension on new limited-service hospitals entering the Medicare program because physicians who own specialty hospitals and then steer healthy and well-insured patients to them have a clear conflict of interest. Congress directed CMS to continue that suspension for up to eight months in the FY 2006 reconciliation bill to allow CMS to develop a strategic report to Congress on the issue. That report is due this summer, and will include recommendations that address the amount of physician investment in specialty hospitals and how these facilities provide care to Medicaid and uninsured patients. Barring self-referral is meant to protect the best interests of all patients and communities. Studies have shown that the practice hurts communities' full-service hospitals that provide a wide range of services including being open 24 hours a day, seven days a week, taking all who come through the emergency room doors.

- **Fix the "75% Rule" for rehabilitation patients**

We'll continue our work toward a permanent fix to the "75% Rule," which requires that, to be reimbursed as an inpatient facility under Medicare, 75% of a rehabilitation facility's patients must be treated for a set of 13 specific conditions. But that set of conditions has not been adequately updated to reflect modern medical rehabilitation practices and advances. The result: the rule is preventing people from getting the care they need. Congress

recently slowed a phase-in of the rule's implementation, adding a second year at the 60% level before the phase-in continues to 65% in 2007 and 75% in 2008. Meanwhile, we'll work for improvements that ensure the 75% Rule truly reflects today's practice of rehabilitation medicine, so that all who need such care get it.

- **Address the challenges in caring for people in rural areas**

  - ✓ We will continue our advocacy for the Rural Community Hospital Assistance Act, which creates a new payment system that makes hospitals with between 25 and 51 beds eligible for cost-based reimbursement for Medicare inpatient and outpatient services, and expands cost-based reimbursement for Critical Access Hospital (CAH) skilled nursing facilities, home health services and ambulance services.

  - ✓ We will advocate for the Rural Health Equity Act, which ensures that Medicare Advantage plans pay CAHs at least 101 percent of costs for inpatient and outpatient services, regardless of weather the CAH has a contract with the patient's Medicare Advantage plan.

  - ✓ The 340b drug discount program allows safety net hospitals to purchase pharmaceuticals at significantly reduced rates for outpatient services. CAHs are unable to participate because they do not receive Medicare disproportionate share hospital payments under inpatient PPS, on which eligibility for the program is based. The AHA will continue to advocate for the Safety Net Inpatient Drug Affordability Act – legislation that expands the 340b program to include inpatient services and allow CAHs to participate.

  - ✓ We will fight CMS' regulatory overreach on its provisions guiding the relocation of CAHs. In addition to restricting definitions of mountainous terrain and secondary roads, CMS would review after one year whether the relocated hospital continues to serve 75% of the same population, provide 75% of the same services and employ 75% of the same staff. Necessary providers that fail the 75% test would lose their CAH status and be forced to convert back to the inpatient PPS, hurting these facilities' ability to continue providing care in their communities.

- ✓ We will advocate for the Critical Access to Clinical Lab Services Act, which would reinstate cost-based reimbursement to CAHs for lab services provided to patients who are not physically present in the hospital.

- ✓ We support the Sole Community Hospital Preservation Act, which would make permanent the hold harmless provision for outpatient services for SCHs.

- ✓ The AHA supports the Medicare Rural Home Health Payment Fairness legislation which would provide for a two-year extension of the temporary 5 percent Medicare payment increase for home health services furnished in rural areas.

- ✓ We'll also work to ensure that important rural health care programs receive adequate funding in the regular congressional appropriations cycle, through which federally funded programs receive their annual funding amounts. Among the programs for which we advocate annually: Rural Health Outreach Grants, Rural Health Research, Rural Hospital FLEX Grants and State Offices of Rural Health. (See attachment for the President's proposed spending levels for select health programs.)

- **Other key resource issues on our priority list**

  - ✓ An amendment in last year's budget bill regulates the rate out-of-network hospitals and their emergency departments (EDs) are paid by Medicaid managed care plans. The provision would cut payments to hospitals by paying the Medicaid fee-for-service rate (minus any indirect and direct graduate medical education payments, where applicable), for such care, instead of allowing these rates to be negotiated between plans and hospitals. This unfair provision further burdens hospitals and EDs that already treat high numbers of uninsured patients, illegal immigrants and others, cutting hospital ED care by at least $60 million over the next five years under Medicaid, with tens of millions of dollars more in cuts from hospitals that will accrue to managed care plans. We'll work to repeal the provision before its January 2007 implementation.

- ✓ We'll advocate for appropriations that provide health care workforce programs with sufficient funding. These programs include Title VII of the Public Health Service Act, which encompasses a variety of allied health programs; National Health Service Corps; trauma care; and nurse education programs, including provisions of the Nurse Reinvestment Act. We'll continue our efforts to ensure that well-qualified foreign educated nurses and physicians can work in the U.S. (See attachment for the President's proposed spending levels for select health programs.)

- ✓ We'll urge Congress and the government to address pandemic flu preparedness issues, including expanding stockpiles of vaccine, making sure front-line health care workers are at the top of the priority list for vaccinations, and addressing liability issues for hospitals where immunizations are provided. Funding for this effort stands at $3 billion, which must be appropriated yearly.

- ✓ Currently, hospitals and other employers are required to invest cash annually or quarterly in their employees' defined benefit pension plans. This year lawmakers will work on a permanent replacement of the 30-year Treasury bond rate as a benchmark for pension plan contributions. In recent years, the 30-year Treasury bond rate has dipped to an all-time low and lead to artificially high pension contributions that divert critical hospital resources from day-to-day needs, without any real benefit to the financial health of pension funds. The AHA will work for a proper balance that helps ensure employees' long-term financial stability without impeding hospitals' ability to take care of people.

- ✓ Congress recently froze physician Medicare payments for one year to avoid a scheduled 4.4% cut in their Medicare payment update. We are supportive of fair and adequate payment rates for physicians, and of efforts to tie reimbursement rates to reasonable measures of quality over the entire health care sector.

- ✓ Several spending programs require annual congressional appropriation. We will support full funding for Children's graduate medical education and National Hospital Bioterrorism Preparedness, in addition to working

to limit government red tape surrounding distribution of those preparedness funds. We also will support supplemental Medicaid funding aimed at helping relieve the financial burdens hospitals have taken on in providing care for victims of Hurricane Katrina who may have been forced from their home states. (See attachment for the President's proposed spending levels for select health programs.)

Strengthen the Bond

- **The AHA will continue its national leadership role in the Hospital Quality Alliance to improve quality of care and patient safety, and to get patients the information they need to make better decisions.**

  ✓ Through HQA, a public-private partnership of hospitals, the government, business and quality management organizations, hospitals submit quality performance data to a government Web site that consumers can use to make better-informed decisions about their health care services. We will help expand the data that will be available through HCAHPS, the first nationally uniform survey measuring patients' experiences with the care they received in the hospital; that new data collection will begin later this year, with information appearing for the first time on the Hospital Compare Web site (www.hospitalcompare.hhs.gov) in late 2007.

  ✓ To help reduce the incidence of specific post-surgical complications, the AHA will continue its leadership on Surgical Care Improvement Project (SCIP). SCIP is designed to provide hospitals, physicians, nurses and other caregivers with effective strategies to reduce four common surgical complications: surgical wound infections, blood clots, perioperative heart attack and ventilator-associated pneumonia. The strategies are based on the best available science and will be refined and improved as new scientific information becomes available. SCIP is one of the first national quality improvement initiatives to unite national hospital, physician and nursing organizations; the federal government; the organization that accredits hospitals; and private sector experts in far-reaching quality improvement and patient safety efforts.

- ✓ As more information on hospital quality becomes available, interest in fostering quality improvement through payment strategies has increased. The AHA supports efforts that would reward performance excellence, called "pay for performance" or incentive-based approaches, that use process measures like those included as part of the Hospital Quality Alliance, give every hospital the opportunity to improve and succeed, and are based on rewards, not penalties.

- ✓ Information technology (IT) has an important role to play in advancing health care – from improving patient safety and outcomes to helping control rising health care costs. Hospitals have seen the great potential for patients and caregivers and many are working to incorporate technology into care delivery. We will work to ensure that the federal government provides leadership in guiding health IT adoption, including federal funds for hospitals to invest in IT equipment, and further development of interoperability standards.

- **The AHA will help hospitals share with local leaders and others the many ways they serve the community, and ensure that all are treated equitably and with dignity.**

  - ✓ Through a new initiative, "Community Connections," the AHA will provide hospitals with tools and resources they can use to strengthen their bonds with their communities, to make sure their communities and elected leaders understand the many ways that each hospital benefits the community it serves. Community Connections will supply members with ideas and innovations from other hospitals and give CEOs strategies to help them listen to, communicate and collaborate with others and be sure that they reaffirm their rightful place as a valued, vital community resource that merits broad public support.

  - ✓ The AHA is committed to supporting our members as they work to assure patients that they will be treated equitably, and with dignity, respect and compassion, from the bedside to the billing office. By expanding on the AHA's billing and collections principles and guidelines that have helped many members shape their policies for assisting patients unable to pay for part or all of their care, hospitals will be able to

better balance their twin responsibilities of serving the uninsured and meeting the challenge of keeping their doors open for all who may need care in a community.

Help People Get Care

- **The AHA will continue its work with other national organizations to develop solutions to the uninsured crisis and help more people afford the care they need.**

  ✓ There are nearly 46 million Americans without health insurance coverage, a number that continues to rise from year to year. Even the insured worry that they will not be able to afford needed care or that they will lose their insurance coverage, with businesses frustrated about the rising cost of providing insurance for their workers. While our health care system is often praised for the range of choices we have of doctors, hospitals and services, access to that care depends on the type of insurance coverage people can afford. We will continue to work with our national partners and the Robert Wood Johnson Foundation to raise awareness and to educate the public and policymakers about the impact that the uninsured crisis is having on people's lives, and on the ability of health care providers to take care of them.

  ✓ We will advocate for reauthorization of the State Children's Health Insurance Program, which expires next year. By matching federal and state funds, SCHIP helps millions of the nation's neediest children maintain health care coverage that they otherwise would not have.

  ✓ We will work with business leaders and others at the national level to spur both national and local partnerships aimed at helping improve people's lives and better coordinate health care. For example, nearly 80 percent of Medicare dollars are spent taking care of just 20 percent of Medicare beneficiaries; almost half the health care costs for non-elderly employees are for those with multiple chronic conditions. Creating better ways to coordinate the care of chronically ill people, and helping people overall engage in preventive health care practices as well, can go a long way toward addressing the rising cost of care nationally.

- **The AHA will take a leadership role in educating the public and elected leaders about the value of our nation's investment in health care.**

  As lawmakers and others address various issues surrounding rising health care costs, a critical factor is frequently missing from the discussion: The value of our nation's investment in health care. In fact, according to a recent study, each additional dollar spent on health care services during the 20-year period prior to the year 2000 produced $2.40 to $3 in tangible gains. In addition, hospitals are economic engines in their communities. They often are the largest employers in their communities and a major reason why new businesses choose to locate in a community. The AHA in 2006 will expand on this concept in several ways, including highlighting specific cases that illustrate the value of investment in health care services, and developing a tool that employers can use to measure the value of their own investment in health care for their employees.

Attachment

The President's Proposed Medicare and Medicaid Budget Cuts for FY 2007

MEDICARE

President Bush proposed almost $36 billion in cuts to Medicare over five years in his fiscal year (FY) 2007 federal budget. Based on the information provided by the Centers for Medicare & Medicaid Services, these cuts to Medicare include:

- A reduction in the market basket update for inpatient and outpatient care of 0.45% in FY2007; of 0.4% in FY2008, and of 0.4% in FY2009. **($8.1 billion)**
- A freeze in the payment update for inpatient rehabilitation facilities for 2007 and an update of market basket minus 0.4% in 2008 and 2009. **($1.6 billion)**
- A freeze in the payment update for skilled nursing facilities for 2007 and an update of market basket minus 0.4% in 2008 and 2009. **($5.1 billion)**
- A freeze in the payment update for home health care for 2007, and an update of market basket minus 0.4% in 2008 and 2009. **($3.5 billion)**
- A four-year phase out of reimbursement for Medicare bad debt. **($6.2 billion)**
- Adjust payment for hip and knee replacements in post acute settings. **($2.4 billion)**
- The Administration also proposed an overall Medicare spending cap, which, if exceeded, would require automatic across-the-board cuts to all provider payments that could be significant.

The AHA estimates that about $19 billion will come from cuts to America's hospitals.

MEDICAID

President Bush's proposed $13.6 billion cuts to Medicaid payments over five years. The AHA estimates that about $5.8 billion will come from hospitals.

- Limiting payments to public providers through IGT and UPL restrictions**.** **($3.8 billion)**
- Reducing the allowable provider tax from 6% to 3%. **($2.1 billion)**

Here's a look at the President's proposed recommended funding levels for selected health care programs:

Comparison of Recommended Funding Levels for Selected Appropriations Programs (in millions of dollars)		
Program	**President's Proposed FY 2007**	**FY 2006 Funding Level**
National Health Service Corp	$126	$126
Rural		
Rural Health Outreach	$10	$39
Rural Health Policy Development	$9	$9
Rural Hospital FLEX grants	$0	$64
Telehealth	$7	$7
Rural Health Total	$26	$119
Nurse Education		
Nurse Loan Repayment/ Scholarship	$31	$31
Advanced Nurse Education	$57	$57
Nursing Education and Retention	$37.3	$37.3
Nursing Workforce Diversity	$16.1	$16.1
Nursing Faculty Loan	$4.8	$4.8
Comprehensive Geriatric Education	$3.4	$3.4
Nurse Education Total	$149.6	$149.6
Health Professions Training	$0	$99
Nat'l Hospital Bioterrorism Preparedness	$474	$474
Children's GME	$99	$297
Trauma Care	$0	$0