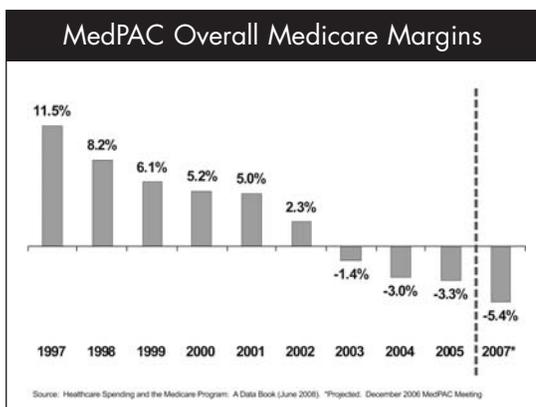


Ensuring Adequate Resources for Patients and Communities

Medicare

Issue

From providing life-saving therapies to patients with chronic illnesses to responding quickly in emergencies to delivering new life, hospitals treat the people in their communities with compassion and empathy 24 hours a day, 365 days a year. But growing financial pressures are making it difficult for hospitals to continue to fulfill their mission of caring for patients.



Medicare payments to hospitals remain well below the cost of providing care to patients. Earlier this year, Congress' independent, non-partisan Medicare Payment Advisory Commission (MedPAC) reported that Medicare payments are falling further and further below the cost of caring for seniors. MedPAC estimates aggregate Medicare hospital margins of negative 3.1 percent in 2005 and projects that those margins will fall to negative 5.4 percent in 2007 – the lowest Medicare margins recorded in over a decade. This trend is unsustainable and unacceptable.

At the same time, hospitals face enormous cost pressures – new and costly pharmaceuticals and information technologies, labor shortages and preparing for pandemics and terrorist threats. In this unpredictable environment, hospitals need adequate Medicare reimbursement to ensure that all patients can receive the care they need. Hospitals cannot sustain further cuts in Medicare payments.

AHA View

As part of the AHA's advocacy agenda, we will work to ensure hospitals have adequate resources to provide high-quality care and meet their responsibilities to their communities. That means fighting any cuts in hospital payments and working to extend expiring Medicare provisions, such as holding the "75% Rule" for inpatient rehabilitation hospitals and units at the 60 percent level and increasing home health payments by 5 percent for rural hospitals, among others. The AHA also will encourage Congress to improve the financial condition of rural hospitals, which face unique circumstances.

The discussion below focuses on the numerous challenges currently facing hospitals.

The White House. The Administration has proposed \$76 billion in legislative and regulatory Medicare cuts over the next five years, including about \$14 billion in inpatient and \$3 billion in outpatient reductions in its fiscal year (FY) 2008 budget proposal. These cuts would be detrimental to the elderly and disabled, and their caregivers.



To protect the Medicare program and its beneficiaries, the AHA spearheaded a grassroots campaign with our members to educate Congress about the severe consequences of such cuts on patients and communities. In addition, the Coalition to Protect America's Health Care, which includes the AHA, launched an advertising campaign to encourage the public to tell Congress to stop the proposed cuts.

The result: a bipartisan group of 223 House lawmakers, led by Reps. Richard Neal (D-MA) and Phil English (R-PA), and 43 senators, led by Sens. Blanche Lincoln (D-AR) and Pat Roberts (R-KS), signed letters to their budget leaders calling for Congress to protect hospital services under Medicare. In late March, both the Senate and House rejected Medicare cuts to hospital services when they passed their budget resolutions. However, under Congress' new pay-as-you-go rules, any new expenditure needs to be offset by cuts to existing programs or tax increases. Consequently, the threat to hospital cuts will exist throughout the year. **The AHA will continue to oppose any Medicare payment cuts for hospital services.**

Medicare Bad Debt. The Administration proposed to eliminate payment for Medicare "bad debt." Nearly 90 percent of Medicare beneficiaries have some type of supplemental insurance coverage to help pay for Medicare's deductibles and co-payments. For seniors without supplemental coverage – many of whom are on fixed incomes – contributing their share of the total Medicare payment can be difficult, and many are unable to pay. These uncollected amounts, or Medicare bad debts, total more than \$1.5 billion a year for hospitals.

Prior to the *Balanced Budget Act of 1997 (BBA)*, Medicare reimbursed hospitals 100 percent of Medicare-related bad debt, but the BBA reduced Medicare reimbursement for bad debt to 55 percent of cost. Congress increased bad debt reimbursement to 70 percent in the *Benefits Improvement and Protection Act of 2000*. However, the Administration now proposes to completely eliminate reimbursement for Medicare bad debt over four years – a move that would cut payments to all hospitals, including critical access hospitals (CAHs), by more than \$7 billion over the next five years. Eliminating Medicare bad debt reimbursement to hospitals sends the wrong message to America's seniors and could limit access to hospital services.

Indirect Medical Education. The Administration's budget also proposes legislative changes to payments for indirect medical education (IME), which provide teaching hospitals with additional funds for the indirect costs associated with the medical education of residents. In particular, the budget proposes cutting IME payments that are made directly to hospitals for treating Medicare Advantage patients. Targeting IME payments to hospitals for reductions may lead to reduced access to high-caliber patient care and medical education for our future physicians. **We urge Congress to consider the benefits provided by teaching hospitals and reject IME cuts.**



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Inpatient PPS. The Centers for Medicare & Medicaid Services' (CMS) proposed inpatient prospective payment system (PPS) rule for FY 2008 would impose drastic cuts on Medicare payments to hospitals. In particular, the agency proposes a 2.4 percent cut to all hospitals in 2008 and 2009 in anticipation of coding changes CMS says hospitals might make under a new severity diagnosis-related group (DRG) system. CMS would create 745 new Medicare-Severity DRGs to replace the current 538 DRGs, and would overhaul the complication or comorbidity list. The reclassification would create up to three tiers of payment for each diagnosis. The rule also proposes eliminating the capital update for urban hospitals and the large urban add-on to capital payments. CMS also is considering discontinuing the teaching and disproportionate share hospital adjustments to capital payments. The rule includes a market basket update of 3.3 percent for those hospitals that submit data on 27 quality measures; hospitals not submitting data would receive a 1.3 percent update. **The AHA is analyzing the rule to understand its full impact; however, we oppose the 2.4 percent “behavioral offset” and cuts to capital payments, which will cut payments to hospitals by over \$25 billion over the next five years.** The AHA will work with the hospital field to develop our position and best response to the regulation.

Medicare wage index. The Tax Relief and Health Care Act of 2006 requires MedPAC to recommend possible alternatives to the Medicare area wage index by June 30. CMS must consider these recommendations in its FY 2009 hospital inpatient PPS proposed rule. To consider possible reform of the area wage index, the AHA has convened a workgroup of national, state, regional and metropolitan hospital association executives. We agree that the area wage index is not functioning well and requires change. In particular, the current system is volatile – neighboring counties can have very different indices, and a hospital's wage index can drop even when the hospital increases wages substantially.

The AHA and its workgroup will continue to work with MedPAC and CMS throughout the next two years to develop potential changes that will address some of the existing area wage index's shortcomings.

Physician Payment. The formula for determining Medicare physician payments is severely flawed and, in recent years, has resulted in proposed negative payment adjustments for physicians, absent congressional action. The Congressional Budget Office recently projected that Medicare physician payment rates would be reduced by 10 percent in 2008, while the 2006 Medicare Trustees report predicts a total of nearly 40 percent in cuts by 2015. Congress must find a permanent, long-term replacement for this flawed payment formula. **The AHA supports correcting the physician payment formula; however, we oppose any attempts to fix it by reducing payments to hospitals.**



Inpatient Rehabilitation Hospitals and Units. Inpatient rehabilitation facilities treat seriously ill and injured patients, but restrictive Medicare policies, such as the 75% Rule and stringent definitions of “medical necessity,” are making it more difficult for these patients to get the care they need. The 75% Rule is one of the criteria an inpatient rehabilitation facility must satisfy to be eligible for Medicare reimbursement under the inpatient rehabilitation PPS. When fully phased in, 75 percent of patients discharged must be treated for one of 13 conditions in order to qualify for rehabilitation-specific payments. Currently, the patient threshold is set at 60 percent, but it is set to rise to 65 percent in July and 75 percent in July 2008. The Moran Group, a Washington, DC-based health care research and consulting firm, recently found that nearly 88,000 patients were unable to receive care in rehabilitation hospitals and units during the first two years of the 75% Rule phase-in – an assessment that far exceeds CMS’ estimate that only 7,000 fewer patients would be treated. CMS’ policies have severely reduced access beyond what was intended.

The AHA is equally concerned that many Medicare fiscal intermediaries (FIs) have further restricted the number of patients who can be treated at inpatient rehabilitation hospitals and units by establishing local coverage determinations (LCDs) based on overly stringent definitions of “medical necessity.” As a result, patients who should be eligible for rehabilitation care are being turned away. And, because no uniform standards exist, some FIs are employing far more restrictive standards than others, creating an unfair competitive environment for inpatient rehabilitation hospitals and units that are located in the same community but have different FIs.

The AHA supports removing overly restrictive LCDs and ensuring all FIs use the national guidelines currently in place for medical necessity. That’s why we will urge Congress to pass the *Preserving Patient Access to Inpatient Rehabilitation Hospitals Act of 2007 (H.R. 1459/S. 543)*, introduced by Reps. John Tanner (D-TN), Kenny Hulshof (R-MO), Nita Lowey (D-NY), and Frank LoBiondo (R-NJ), and Sens. Ben Nelson (D-NE), Jim Bunning (R-KY), Debbie Stabenow (D-MI), and Olympia Snowe (R-ME), respectively. **The bill would freeze the 75% Rule at the current 60 percent level and address inconsistent and harsh LCDs.**

Long-term Care Hospitals. CMS’ rate year 2008 proposed rule for long-term care hospitals (LTCHs) recommends several troubling changes – most notably CMS’ plan to extend the “25% Rule” to all LTCHs, including freestanding and satellite facilities, as well as LTCHs that were exempted from the original 25% Rule. In FY 2005, CMS implemented the 25% Rule for LTCHs that were co-located within acute care hospitals. When fully phased in, this policy would require that only 25 percent of admissions to the LTCH can be patients who were previously admitted to the co-located acute care hospital. For LTCHs exceeding this 25 percent patient threshold, currently at 50 percent, CMS will reimburse the LTCH at the lower payment rate for general acute care hospitals. Expansion of the 25% Rule would



reduce payments in 2008 to LTCHs by 2.9 percent, or \$117 million.

The AHA supports efforts to more specifically define patient and facility criteria for LTCHs. However, the 25% Rule misses the mark by not focusing on patients' clinical characteristics. LTCHs provide intense care to patients who require longer lengths of stay than typical patients in a general acute care hospital, such as those on ventilators or burn victims. Any proposed policy regarding LTCHs should ensure access for patients for whom LTCH care is medically appropriate – a view supported by MedPAC.

Last year, CMS released a report by the Research Triangle Institute (RTI) that identified feasible patient and facility criteria that would help distinguish LTCHs from other acute care facilities. However, CMS has not yet used the report to produce specific policy recommendations. **Rather than limiting access to LTCH services through payment cuts, we urge CMS not to move forward with the proposed rule, but to work with the RTI and LTCH providers to develop appropriate facility and patient-centered criteria to determine the types of patients that should be treated in LTCHs.**

Rural Hospitals. Rural hospitals provide essential health care services to nearly 54 million people, including 9 million Medicare beneficiaries. Because of their small size, modest assets and financial reserves, and higher percentage of Medicare patients, these hospitals face enormous pressures as government payments decline. Yet, Medicare margins are the lowest for rural hospitals, with the smallest hospitals having the lowest margins.

National payment policies, specifically prospective payment systems, often fail to recognize the special characteristics and unique circumstances of small rural hospitals. Many rural hospitals are too large to qualify for CAH status but too small to absorb the financial risk associated with PPS programs. **As a result, the AHA will advocate for Congress to pass the following legislation, which was introduced earlier this year:**

- ***The Sole Community Hospital Preservation Act*** (H.R. 1177) – Introduced by Reps. John Tanner (D-TN) and Sam Graves (R-MO), this bill would extend permanently the outpatient PPS hold harmless and permit the use of a more current year to allow re-determination of the hospital target amount.
- ***The Physician Pathology Services Continuity Act*** (S. 458/H.R. 1105) – This bill, introduced by Sens. Blanche Lincoln (D-AR) and Craig Thomas (R-WY) and Reps. John Tanner (D-TN) and Kenny Hulshof (R-MO), would permanently extend the grandfather clause to allow Medicare to continue to make direct payments to independent laboratories for the technical component of pathology services.



The AHA also will work to extend expiring legislative provisions, including a home health 5 percent rural add-on, cost-based payment for rural laboratory services provided by hospitals with less than 50 beds and ambulance mileage bonuses for transport of rural patients in low-population density areas. In addition, the AHA will work to expand existing cost-based payment to home health and skilled nursing facility settings for CAHs and to rural hospitals with 25-50 beds for inpatient and outpatient services; to allow flexibility for CAH relocation; to allow CAHs to be used as reference labs to provide services to beneficiaries; and to ensure CAHs are paid at least 101 percent of costs by Medicare Advantage plans.

340B Drug Discount Program. Safety-net hospitals depend on the 340B drug discount program to provide pharmacy services to some of their most vulnerable patients. Currently, the program is available only for outpatient services provided at disproportionate share hospitals. However, these hospitals, often with poor financial margins, are unable to benefit from the program for the pharmacy services they furnish to inpatients. **Therefore, the AHA will work to make drug prices under the 340B outpatient drug discount program available for inpatient services at 340B hospitals.** We also will seek to expand eligibility to CAHs, sole community hospitals, Medicare-dependent hospitals and rural referral centers, which serve as the rural safety net.