

# Ensuring Adequate Resources for Patients and Communities

## *Medicare*

### Issue

America's hospitals have a long tradition of providing care for all who seek it. But that mission is threatened by a poorly funded Medicare program. Recently, Congress' independent, non-partisan Medicare Payment Advisory Commission (MedPAC) reported that Medicare payments continue to be well below the cost of caring for America's seniors. They estimate that aggregate Medicare hospital margins in 2008 will be *negative* 4.4 percent – a near record low margin. This trend is unsustainable and unacceptable.

At the same time, hospitals face enormous cost pressures associated with, among other things, labor shortages, new pharmaceuticals, the adoption of information technology and preparation for pandemic and terrorist threats. In today's unpredictable environment, hospitals need adequate Medicare reimbursement to ensure that our patients and communities receive the care they expect and deserve. Hospitals cannot survive further cuts in Medicare payments.

### AHA View

The AHA's 2008 advocacy agenda focuses on ensuring hospitals have the resources they need to provide high-quality care and meet the needs of their communities. That means fighting any cuts in hospital payments; working to extend expiring Medicare provisions; encouraging Congress to shore up payments for hospitals that train the physicians of the future; improving Medicare payments to rural hospitals; and reining in overzealous and unfair Medicare claims denials by Recovery Audit Contractors (RACs) and similar activities of Medicare's fiscal intermediaries (FIs).

**The FY 2009 Budget.** The Administration in its fiscal year (FY) 2009 budget proposed an unprecedented \$182 billion over five years in legislative and regulatory Medicare cuts – of which, more than \$135 billion would come from inpatient, outpatient, acute long-term care and inpatient rehabilitation services through a freeze in updates for FY 2009-2011 and then an update of marketbasket minus 0.65 percentage points each year thereafter. Also, indirect medical education (IME) payments to hospitals for Medicare Advantage beneficiaries would be eliminated; the IME payment adjustment would be reduced from 5.5 percent to 2.2 percent over three years; hospital capital payments would be reduced by 5 percent in FY 2009; and hospital disproportionate share (DSH) payments would be reduced by 30 percent over two years. The proposal also would lower the base payment rates for inpatient rehabilitation facilities for five post-acute conditions, expand the post-acute transfer provision for discharges to home health from three days of discharge to within seven days of discharge, and eliminate payment for serious, adverse events.



To protect the Medicare program and its beneficiaries, the AHA spearheaded a grassroots campaign to educate Congress about the severe consequences of such cuts on patients and communities. As a result, a bipartisan group of 265 House lawmakers, led by Reps. Richard Neal (D-MA) and Phil English (R-PA), and 59 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.

While the House and Senate budget resolutions did not include the Administration's proposals, the threat of hospital cuts still exists. The House budget blueprint includes reconciliation instructions directing the House Ways and Means Committee, which has jurisdiction over a number of programs including Medicare, to develop legislation that decreases spending or increases revenues by \$750 million over five years. Also, new spending rules require any new expenditure to be offset by cuts to existing programs or by increasing taxes. **The AHA will continue to oppose any Medicare payment cuts for hospital services.**

**Inpatient PPS Rule.** The Centers for Medicare & Medicaid Services' (CMS) FY 2009 inpatient prospective payment system (PPS) proposed rule will continue the implementation of the Medicare-Severity diagnosis-related group (MS-DRG) system and the corresponding changes to the list of complications and comorbidities.

*Inpatient Capital IME Payments.* CMS is required to pay for a portion of the capital-related costs of inpatient hospital services. This is done through a separate inpatient capital PPS that includes outlier payments for unusually costly patients and IME and DSH adjustments similar to those made under the operating PPS. In its FY 2008 final rule, CMS eliminated the 3 percent add-on to capital payments for hospitals in large urban areas and reduced the IME adjustment to capital payments by 50 percent in FY 2009 with no IME payments in FY 2010 and thereafter.

Eliminating the IME adjustment – which teaching hospitals rely on to help cover the costs of training our nation's future physicians – from the capital PPS will reduce payments to teaching hospitals by \$1.3 billion over five years. Medicare's capital payments, including the increased payment to cover the costs of IME, are vital to investing in the latest medical technology, ongoing maintenance and improvement of hospital facilities. **The AHA will work with Congress to reverse these cuts.**

*Medicare Area Wage Index.* The *Tax Relief and Health Care Act of 2006* mandated that MedPAC recommend possible alternatives to the Medicare area wage index (AWI). Their recommendations, which CMS must consider in its FY 2009 inpatient PPS proposed rule, would dramatically change the source data and methodology of calculating the AWI.

The AHA agrees 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. To address this and other issues with the AWI, the AHA convened a workgroup of national, state, regional and metropolitan hospital association executives. **The AHA and its workgroup will work with MedPAC, CMS and the Congress to develop potential changes that will address some of the shortcomings of the AWI.**

**Pay-for-Performance.** Interest in moving toward pay-for-performance in the Medicare program is accelerating. Hospitals already are subject to pay-for-reporting requirements. In order to receive a full Medicare inpatient PPS market basket update, hospitals must report certain quality measures, and the same will apply to the calendar year 2009 outpatient PPS payment update. As required by the *Deficit Reduction Act of 2005*, CMS last year issued a report to Congress outlining options for moving ahead with a pay-for-performance or “value-based purchasing” incentive program that would reward hospitals for meeting certain performance thresholds. However, the Administration in its FY 2009 budget proposed to move forward with a strategy that would focus more on budget savings than on improving performance and quality – cutting \$1.7 billion from Medicare payments over five years. **The AHA will urge Congress to continue to reject any pay-for-performance initiatives that reduce payments to hospitals.**

The hospital field supports the concept of aligning payment incentives with the provision of high-quality care, but recommends moving forward with care. A new incentive system should:

- align hospital and physician incentives to encourage all to work toward effective and appropriate care;
- be developed collaboratively with all stakeholders;
- be focused on improving quality, not as a cost cutting mechanism;
- recognize and reward both high levels of performance and substantial improvements;
- use measures that are evidence-based, important and collectable and recognize differences in patient populations; and
- be designed carefully so as not to perpetuate disparities in care.

**Physician Payment.** The Medicare physician payment formula is severely flawed and, in recent years, has resulted in significant payment cuts for physicians. The Congressional Budget Office projected that 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. The *Medicare, Medicaid and SCHIP Extension Act of 2007* provided for a 0.5 percent increase to the Medicare Physician Fee Schedule conversion factor for the first six months of 2008 instead of the negative 10.1 percent cut that was scheduled to take place. However, the 10.1 percent cut will go into effect after July 1 unless Congress intervenes. **The AHA supports preventing Medicare physician payment cuts as well as a permanent, long-term replacement for this flawed payment formula; however, Congress should not attempt to address it by reducing payments to hospitals.**



**Inpatient Rehabilitation Hospitals and Units.** The *Medicare, Medicaid and SCHIP Extension Act of 2007* permanently set the “75% Rule” compliance threshold at 60 percent and allows the continued use of certain comorbidities to count toward compliance. The law freezes payments at the 2007 level for six quarters – April 2008 through September 2009 – and applies the 2010 update to the 2007 standard rate. **The AHA will work with Congress to oppose any further cuts for inpatient rehabilitation.**

The AHA remains concerned about aggressive and inconsistent medical necessity review of inpatient rehabilitation by FIs and RACs. AHA research indicates 63 percent of appealed FI denials were overturned in favor of the provider. Still, confusion caused by a lack of transparency and inconsistent policy interpretations, and the burden and cost associated with appealing these denials, have reduced access and resources for patients who need inpatient rehabilitation. **The AHA urges CMS to expand and improve oversight of its contractors to ensure fair and consistent medical necessity review of inpatient rehabilitation.**

**Rural Hospitals.** Because of their small size, modest assets and financial reserves, and higher percentage of Medicare patients, rural hospitals rely disproportionately on government payments. While their Medicare margins have improved in recent years, more than 60 percent still lose money treating Medicare patients.

Medicare payment systems 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 PPS programs. Also, special rural payment programs that exist – CAH, sole community hospital (SCH), Medicare dependent hospital and rural referral center – need to be updated. **The AHA urges Congress to pass the following legislative relief:**

- *The Sole Community Hospital Preservation Act (H.R. 1177).* Introduced by Reps. John Tanner (D-TN) and Sam Graves (R-MO), this bill would permanently extend 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 Sen. Blanche Lincoln (D-AR) and Reps. John Tanner (D-TN) and Kenny Hulshof (R-MO), would permanently extend the provision to allow Medicare to continue to make direct payments to certain independent laboratories for the technical component of pathology services.
- *The Rural Health Services Preservation Act (S. 630/H.R. 2159).* Introduced by Sens. Norm Coleman (R-MN), Richard Durbin (D-IL) and Tom Harkin (D-IA), and Reps. Ron Kind (D-WI) and Cathy McMorris Rodgers (R-WA), this bill would ensure CAHs receive at least 101 percent of costs for inpatient, swing-bed and outpatient hospital services, and rural health clinics receive the applicable all-inclusive rate for services provided to Medicare Advantage patients.



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The AHA will work to extend provisions contained in the *Medicare, Medicaid and SCHIP Extension Act of 2007* which expire this year. Provisions expiring June 30 include cost-based reimbursement for outpatient clinical lab tests performed by certain small, rural hospitals and a provision that would, like S.458/H.R. 1105, allow independent laboratories to continue to bill Medicare directly for the technical component of certain physician pathology services. The Section 508 geographic reclassification expires September 30. Section 508 of the Medicare Modernization Act was a geographic reclassification opportunity for hospitals meeting certain criteria to appeal their wage index classifications. And, the AHA will work to get Congress to reauthorize a 5 percent payment add-on for rural home health services and reinstate the ambulance mileage bonuses for transport of rural patients in low-population density areas.

In addition, the AHA will advocate that Congress enact legislation that would provide for a low-volume adjustment; equalize DSH hospital payments; and extend cost-based reimbursement to rural hospitals with 25-50 beds for all inpatient and outpatient services.

The AHA will urge lawmakers to adopt legislation for CAHs that would provide cost-based reimbursement for outpatient lab services and ambulance services; ensure CAHs are paid at least 101 percent of costs by Medicare Advantage plans; allow CAHs seasonal flexibility to operate an annual average of 20 beds per day (rather than a daily maximum of 25 beds per day); and remove unnecessary and unreasonable restrictions on CAHs' ability to renovate and relocate.

The AHA will seek to allow SCHs the option of using 2002 as a base year for determining inpatient payments and legislation to make permanent the 7.1 percent administrative adjustment to SCH outpatient payments. For Medicare dependent hospitals, the AHA will work to make this special payment program, due to expire in 2011, permanent.

**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. The program only is available for outpatient services provided at DSH hospitals. However, these hospitals, often with poor financial margins, are unable to benefit from the program for the pharmacy services they furnish to inpatients. **The AHA will work to make drug prices under the program available for inpatient services as well, and will seek to expand eligibility to CAHs, SCHs, Medicare-dependent hospitals and rural referral centers, which serve as the rural safety net.**

**Recovery Audit Contractor Program.** The RAC program was authorized by Congress to identify improper Medicare payments – both overpayments and underpayments. Beginning as a demonstration project in California, Florida and New



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York, Congress in 2006 made the RAC program permanent, requiring CMS to expand the program nationwide by 2010. In FY 2007, RACs collected \$357 million in overpayments from Medicare providers in the three demonstration states, with over 90 percent of these funds collected from hospitals.

The AHA has serious concerns with the RAC program and CMS' expansion plans. While CMS has made some positive changes – staggering the expansion schedule, with different states coming under review in 2008 and 2009; prohibiting RACs from reviewing claims with dates of service prior to October 1, 2007; and establishing medical record request limits – more changes are necessary. **The AHA will urge Congress to pass the *Medicare Recovery Audit Contractor Program Moratorium Act of 2007 (H.R. 4105)*, which would place a one-year moratorium on the RAC program.** This legislation, sponsored by Reps. Lois Capps (D-CA) and Devin Nunes (R-CA), would provide Congress, CMS and hospitals with time to address the many serious problems with the RAC program, including the need to establish more appropriate payment incentives as well as greater oversight and transparency of their processes.