

## Background

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 2009 will be *negative* 6.9 percent – a record low. This trend is unsustainable and unacceptable.

At the same time, hospitals face enormous cost pressures associated with, among other things, the worsening economy and credit market, 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.

## AHA View

The AHA's 2009 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 advocating for adequate Medicare payments; encouraging Congress to shore up payments for hospitals that train the physicians of the future; implementing payment reform in a manner that improves care coordination and promotes efficiency; working to extend expiring Medicare provisions; improving Medicare payments to rural hospitals; and reining in overzealous and unfair Medicare claims denials by Recovery Audit Contractors (RACs) and similar activities of fiscal intermediaries and Medicare Administrative Contractors.

**The FY 2010 Budget.** In February, the Obama Administration released a "budget outline" for fiscal year (FY) 2010. While this outline offers few details, the administration announced that it would create a 10-year reserve fund of more than \$630 billion to finance health reform efforts, with half of that amount coming from new revenues such as higher taxes on wealthier Americans, and the other half from program savings, some of which would come from hospitals. Specifically, the budget proposes \$38 billion over 10 years in Medicare cuts that will affect inpatient and outpatient services and long-term care hospitals (LTCHs) and inpatient rehabilitation facilities by linking a portion of inpatient hospital payment to performance on specific quality measures, paying hospitals with certain readmission rates less for patients readmitted within 30 days and bundling payments for hospital and post-acute care. In addition, the budget outline cites the need to address physician self-referral to facilities in which they have an ownership interest. The AHA applauds the administration for recognizing the need to address self-referral, and looks forward to working with it to achieve this policy.

The House and Senate budget resolutions contain a deficit-neutral reserve fund for future health care reform legislation. Unlike the House version, the Senate resolution does not include AHA-opposed reconciliation instructions, a fast-track process that limits debate and requires a simple majority vote for passage. Among other differences, the House resolution does not require that the cost of fixing the Medicare physician payment formula be accomplished in a budget-neutral manner, while the Senate version requires the cost be offset by other cuts. Further, the Senate allows additional flexibility

in meeting the need to provide reductions to pay for health care reform. Differences between the two resolutions will be reconciled in conference after Congress returns April 20.

The AHA is committed to health care reform, which should start with expanding coverage for all, and commends President Obama for making health reform a top priority among the many challenges facing our nation. The president's budget outline presents an incomplete picture, however, as it is unclear what shape entitlement reform and the remainder of health reform will take. Given the economic pressures faced by hospitals, which serve as the nation's health care safety net – and given that Medicare and Medicaid already pay hospitals less than the cost of providing services – it is essential to proceed with caution, as hospital services for people in need already have been cut at the state and local levels. The AHA is concerned about cuts that affect the work hospitals do for their communities, especially during this economic downturn. **The AHA will work with the administration and Congress to avoid detrimental cuts while strengthening health care in America.**

**Inpatient PPS Rule.** The FY 2010 inpatient prospective payment system (PPS) proposed rule will continue efforts by the Centers for Medicare & Medicaid Services (CMS) to address payment increases related to implementing the Medicare-Severity diagnosis-related group (MS-DRG) system. Specifically, CMS believes that adopting the MS-DRGs will lead to coding and classification changes that will increase aggregate hospital payments without a corresponding increase in actual patient severity of illness.

For this reason, and to offset these payment increases, in the FY 2008 inpatient PPS final rule, the agency established a prospective documentation and coding adjustment of negative 1.2 percent for FY 2008, negative 1.8 percent for FY 2009 and negative 1.8 percent for FY 2010. Congress lowered this prospective adjustment to negative 0.6 percent in FY 2008 and negative 0.9 percent in FY 2009. However, for FY 2008 and 2009, CMS has the authority to retroactively collect funds from hospitals this year if the actual increase in hospital payments without a corresponding increase in actual patient severity of illness is more than these negative adjustments. The agency will discuss any proposed retroactive collection in this rule, and also will be evaluating whether its planned adjustment of negative 1.8 percent for FY 2010 is appropriate. **The AHA will work with CMS and Congress, if necessary, to ensure that CMS does not go beyond its charge of ensuring budget-neutral implementation of MS-DRGs.**

**Teaching Hospitals.** Teaching hospitals fulfill critical social missions, including educating and training future medical professionals, conducting state-of-the-art research, caring for the nation's poor and uninsured, and standing ready to provide highly specialized clinical care to the most severely ill and injured patients. The Medicare program has long recognized the value of the enhanced services beneficiaries receive in teaching hospitals, as well as its responsibility for funding its share of the direct and indirect costs of training medical professionals. Medicare's indirect medical education (IME) adjustment was created to help offset some of the higher patient care costs, including the greater use of technologies, in teaching hospitals.

*Inpatient Capital IME Payments.* In its FY 2008 inpatient PPS rules, CMS proposed and finalized a regulation to phase out Medicare IME payments made to teaching hospitals under the capital PPS. The regulation reduced capital IME payments by 50 percent in FY

2009 and completely eliminated them in FY 2010, which cut payments to teaching hospitals by \$1.3 billion over five years.

Last summer, the AHA launched a grassroots campaign that resulted in a bipartisan group of more than 200 representatives and 51 senators signing letters urging CMS to withdraw its capital IME regulation. Unfortunately, CMS moved forward with the rule and hospitals saw their capital IME payments reduced by 50 percent on October 1, 2008.

In January, the AHA again urged Congress to halt the phase out of these critical payments. As a result, the *American Recovery and Reinvestment Act of 2009* stopped the FY 2009 scheduled cuts, thereby restoring \$177 million to teaching hospitals. However, this bill did not address the full elimination of capital IME payments in FY 2010. 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 continue to work with Congress to reverse the scheduled elimination of capital IME payments in FY 2010.**

**Post-acute Care.** The AHA supports efforts to better coordinate care among the different types of providers, including integrated information systems, a common post-acute patient assessment instrument and care coordination for patients transitioning to post-acute care. However, prior to widespread implementation, these and related reform concepts must be tested to ensure that they enhance patient care and improve the delivery system. The AHA will continue working to bring together acute and post-acute care leaders to discuss Medicare reform efforts to improve the overall health infrastructure so patients receive the right care in the right place at the right time.

**In 2009, the AHA is seeking an extension to the LTCH relief on the 25% Rule, short-stay outlier payment cuts and related measures that was provided in the *Medicare, Medicaid and SCHIP Extension Act of 2007*.** The AHA also will oppose any proposed market basket or other payment cuts to LTCHs and inpatient rehabilitation facilities, as well as continue to seek relief from CMS and Congress on the problem of aggressive and inappropriate medical necessity denials by CMS contractors.

**Rural Hospitals.** Because of their small size, modest assets and financial reserves, and higher percentages of Medicare patients, rural hospitals disproportionately rely on government payments. While their Medicare margins have improved in recent years, almost 65 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, existing special rural payment programs – CAH, sole community hospital (SCH), Medicare-dependent hospital (MDH) and rural referral center – need to be updated.

**The AHA urges Congress to pass the following legislative relief:**

- *The Critical Access Hospital Flexibility Act of 2009 (S. 307/HR. 668)*. Introduced by Sens. Ron Wyden (D-OR), Mike Crapo (R-ID) and Rep. Greg Walden (R-OR), this bill would provide flexibility in the manner in which beds are counted for purposes of

determining whether a hospital may be designated as a CAH under the Medicare program, and exempt from the CAH inpatient bed limitation the number of beds provided for certain veterans.

- *The Medicare Rural Health Access Improvement Act of 2009 (S. 318) and the Rural Hospital Assistance Act of 2009 (H.R. 362)*. Introduced by Sen. Charles Grassley (R-IA) and Rep. Leonard Boswell (D-IA), these bills would improve Medicare payments to rural hospitals that are too large to be CAHs, but too small to be financially viable under the Medicare PPS, and would allow MDHs to receive the non-wage-adjusted payment rate and a low-volume adjustment for Medicare inpatient services.

In addition, the AHA will work with Congress to provide small, rural hospitals with cost-based reimbursement for outpatient lab services and ambulance services; ensure CAHs are paid at least 101 percent of costs by Medicare Advantage plans; reinstate the 5 percent rural add-on payment for home health services; remove the cap on disproportionate share hospital (DSH) adjustment percentages for all hospitals; extend and expand the Rural Community Hospital demonstration program; and remove unreasonable restrictions on CAHs' ability to rebuild.

The AHA also will work to extend provisions contained in the *Medicare Improvements for Patients and Providers Act of 2008* that expire this year. For example, section 508 geographic reclassifications, which are geographic reclassification opportunities for hospitals meeting certain criteria to appeal their wage index classifications, expire September 30. Several other provisions expire on December 31, including hold-harmless payments for small rural hospitals (including SCHs with less than 100 beds) and a provision that allows independent laboratories to continue to bill Medicare directly for the technical component of certain physician pathology services.

**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 is available only for outpatient services provided at DSH hospitals – it is not available for pharmacy services provided to inpatients at these hospitals, which often have poor financial margins. **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, MDHs and rural referral centers, which serve as the rural safety net.** We support the *340B Program Improvement and Integrity Act of 2009* (H.R. 444). Introduced by Reps. Bobby Rush (D-IL), JoAnn Emerson (R-MO) and Bart Stupak (D-MI), this bill expands the 340B program to include inpatient drugs at DSH hospitals, and inpatient and outpatient services at CAHs, SCHs, MDHs and rural referral centers.

**Physician Payment.** The Medicare physician payment formula is severely flawed and, in recent years, would have resulted in significant payment cuts for physicians without legislative intervention. Most recently, the *Medicare Improvements for Patients and Providers Act of 2008* replaced the scheduled 10.6 percent payment cut that was to take effect July 1, 2008, with an extension of the existing 0.5 percent update through December 31, 2008, and established a payment update of 1.1 percent for calendar year 2009. Notwithstanding the update adjustments and other payment enhancements enacted in recent years, the flawed physician payment formula remains in current law. For 2010, the Congressional Budget Office (CBO) estimates that, absent a change in current law, physician payments rates will be reduced by 21 percent.

**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 other providers.**

**Payment Reform Efforts.** Concerns over rising health care costs, along with elevated interest in ensuring the highest quality care, have led stakeholders to seek new ways to attain high-quality, cost-efficient care by reforming health care payment. The AHA is steadfast in its commitment to health reform, of which payment reform is a critical aspect. Payment reform efforts should aim to reduce the rate of increase in health care costs and establish appropriate financial incentives that align caregivers to provide higher quality care, encourage coordination of services, promote wellness and utilize comparative effectiveness studies to identify best practices.

*Pay-for-Performance.* Hospitals, more than any other provider type, have a history of linking quality measurement and improvement to payments. Legislation has been put forth and CMS has issued a report to Congress that outlines pay-for-performance or “value-based purchasing” incentive programs that would reward hospitals for meeting certain performance thresholds. However, in its FY 2010 budget outline, the administration proposed a strategy that focuses more on achieving budget savings than on improving performance and quality – cutting \$12.09 billion from Medicare payments over 10 years. The AHA is concerned about upfront payment cuts, since we believe overall savings can be achieved by improved care leading to fewer medical visits. **The AHA will urge Congress to continue to reject any pay-for-performance initiatives that reduce aggregate payments to hospitals.**

**The hospital field supports the concept of aligning payment incentives with the provision of high-quality care, but recommends moving forward thoughtfully and deliberately as the development of incentive-based programs are proving complex.** To be successful, incentive approaches 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.

*Readmissions.* There has been considerable interest from MedPAC, CBO and Washington policymakers in using financial and other incentives to prompt changes in care processes that will reduce hospital readmissions. Readmissions account for a significant amount of Medicare and other payer spending. For example, according to MedPAC, in 2005, approximately 18 percent of Medicare patients discharged from hospitals were readmitted within 30 days, costing the Medicare program approximately \$15 billion. More recently, CBO suggested that the Medicare program could save money if payments to hospitals with high readmission rates were reduced, and the administration included such a provision in its FY 2010 budget outline – cutting \$8.43 billion from Medicare payments over 10 years.

Preventing readmissions is a complex, system-wide problem that involves hospitals, physicians and other providers who manage patients' care, as well as patients and their families. Arbitrary policies that assume many hospital readmissions are not appropriate raise concerns. Determining preventable readmissions is a complex undertaking because the causes behind each readmission are unique – readmissions policies require thorough analysis of both the patient's hospital experience and the care prescribed after discharge. Further, the use of payment or regulatory policies to create incentives to reduce hospital readmissions should be focused not on achieving savings, but on improving the performance of hospitals, physicians and post-acute care providers and providing the best care possible to patients. **The AHA will urge Congress to maintain this focus and reject efforts to use a readmissions payment policy as a further cost-cutting measure for payers.**

*Bundling.* The concept of bundling Medicare payment around a hospitalization also is gaining interest. Bundling provider payment would represent a major change to the Medicare program – perhaps the most substantial change since implementing inpatient PPS 25 years ago. This change could have a significant impact on providers, depending on how it is structured. For that reason, a careful and thoughtful approach to bundling payments is warranted to ensure that changes to the payment system do not result in inequities or other unintended consequences for providers and patients. We must evaluate existing demonstration projects in this arena, consider phasing-in implementation gradually, and provide the appropriate tools and infrastructure for coordinating care and managing risk.

MedPAC has recommended a pilot program to test the feasibility of bundling Medicare payments for hospital, physician and post-acute care for certain conditions. The administration included a provision in its budget outline that would bundle Medicare payments covering hospital and post-acute settings, which would save \$17.84 billion over 10 years. While the AHA believes that the bundling concept may hold merit in the future as a way to improve the coordination of a patient's care among providers and the overall quality of care, as presented in the budget outline, bundling is problematic. The proposal contains no details, yet shows significant savings immediately upon implementation. It does not consider the fact that hospitals and their communities are quite different and may not have the necessary infrastructure in place to proceed with actual bundled payment. Some hospitals are organized in ways that would facilitate bundling payments, but most are not, and they need the tools to be able to do so, such as removal of legal barriers to clinical collaboration. In addition, the administration's proposal does not include physicians in the payment bundle, yet unless hospital and post-acute provider incentives are aligned with physician incentives, it will be impossible to provide both effective and appropriate care and create better health outcomes.

**RAC Program.** CMS is currently rolling out the permanent RAC program in two phases. The prior RAC demonstration program caused significant problems for hospitals in the five demonstration states. Based on that experience, the AHA is working to improve the RAC program through several approaches:

- Working with CMS to make the program more transparent and reasonable for hospitals.
- Offering the AHA RAC Education Series to provide hospitals with resources to help manage RAC audits and appeals.
- Developing legislation for further improvements to the RAC program. Some of the AHA's key legislative remedies include eliminating RAC medical necessity review and establishing a method to re-bill denied claims at a lower payment level.