

# Protecting the Promise of Care

## Medicare

### Background

America's hospitals have a long tradition of providing care for all who seek it. The AHA is committed to health care reform, as stated in *Health for Life*, and believes reform starts with expanding coverage for all, paid for by all. That's why we pushed to ensure all stakeholders shared the responsibilities associated with reform. While the *Patient Protection and Affordable Care Act* (PPACA) is not perfect, it does expand coverage to 32 million people, enact significant insurance market reforms and lay a solid foundation upon which we can continue to build. The PPACA also helps hospitals continue this tradition by extending important Medicare provisions from 508 reclassifications to the rural community hospital demonstration program.

At the same time, hospitals will certainly face pressures associated with the PPACA in addition to challenges presented by the economy, labor shortages, new pharmaceuticals, the adoption of health information technology, the administrative burden of responding to requests from myriad Medicare fiscal contractors and preparation for pandemic and terrorist threats.

**The Fiscal Year 2011 Budget.** In February, the Obama Administration released a budget outline for fiscal year (FY) 2011. The Administration included a "placeholder" for health care reform instead of specific proposals. The budget does not appear to contain cuts outside of those already included in the PPACA to the Medicare program for FY 2011.

The budget also indicated that the President would propose the creation of a commission to balance the budget; he subsequently signed an executive order creating such a commission. The bipartisan commission must deliver a report to the President that makes recommendations to bring annual deficits to no more than three percent of the size of the economy. Currently, annual deficits for the next decade are on track to be well above that level. The commission also is expected to suggest ways to permanently lower the country's total debt; recommendations to cut Medicare and Medicaid spending are widely thought to be options for the group.

The two co-chairmen of the commission are Alan Simpson, a former Republican senator from Wyoming, and Erskine Bowles, a Democrat who served as White House chief of staff under President Clinton.

### AHA View

**Medicare Funding.** The AHA's 2010 advocacy agenda focuses on ensuring hospitals have the resources they need to provide high-quality care and meet the needs of their communities, particularly under health care reform. That means:

- Advocating for adequate Medicare payments;
- Implementing health care reform in a manner that improves care coordination and promotes efficiency;
- Working to extend expiring Medicare provisions;

- Improving Medicare payments to rural hospitals;
- Encouraging Congress to shore up payments for hospitals that train the physicians of the future; and
- Reining in unfair Medicare claims denials by Recovery Audit Contractors (RACs) and similar activities of fiscal intermediaries and Medicare Administrative Contractors.

Given the economic pressures faced by hospitals that 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 continue to lobby the Administration and Congress to oppose detrimental cuts while strengthening health care in America.**

**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. In fact, the AHA created a Task Force on Payment Reform that examined the range of payment proposals related to health reform. Their recommendations included an evolution framework built around forms of payment, performance metrics and barrier removal. The task force also established side paths for organizations such as low-volume rural hospitals that may not be able to make bundled payments work appropriately due to their operating environments. Payment reform efforts such as value-based purchasing, bundling payments and accountable care organizations 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. The PPACA includes pay-for-performance or value-based purchasing (VBP) incentive programs that would reward hospitals for meeting certain performance thresholds. **The AHA worked to ensure Congress tied quality measurement to performance-based hospital payment in a VBP program and did so in a budget-neutral manner that rewards hospitals for either attainment or improvement.**

**Readmissions.** There has been considerable interest from the Medicare Payment Advisory Commission (MedPAC), the Congressional Budget Office (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 portion of Medicare and other payer spending. 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. The PPACA included a readmissions policy that imposes financial penalties on hospitals for so-called "excess" readmissions when compared to "expected" levels of readmissions based on the 30-day readmissions measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program. **The AHA believes that a policy to reduce readmissions should address only avoidable and unplanned hospital readmissions related to the original admission. We strongly disagree with the approach included in the PPACA.** The AHA will work to address the problems in the readmissions policy through the regulatory and legislative process.

**Bundling.** Bundling provider payments would represent a major change to the Medicare program – perhaps the most substantial change since implementing inpatient prospective payment system (PPS) almost 30 years ago. This change would 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. **The AHA worked with Congress to establish incremental approaches that test different models of bundling payments to improve the coordination of care. However, an appropriate evaluation is essential to determine what works and what does not before broad adoption.**

The PPACA requires the Center for Medicare & Medicaid Services (CMS) to develop and test models that would bundle Medicare payment across provider settings and payment systems. However, it requires that the pilot program bundle include inpatient, outpatient, physician and post-acute services. **The AHA will urge Congress and the Administration through the CMS' Center for Innovation to encourage a wider array of models, including bundling, payment for inpatient and physician services; inpatient and post-acute services; inpatient, physician and post-acute services; and post-acute services only.**

**Inpatient PPS Rule.** The FY 2011 inpatient PPS proposed rule will continue efforts by 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 has led to coding and classification changes that have increased aggregate hospital payments without a corresponding increase in actual patient severity of illness.

For this reason, and to offset these payment increases, the FY 2008 inpatient PPS final rule 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. Further, in the FY 2010 inpatient PPS proposed rule, CMS proposed a documentation and coding adjustment of negative 1.9 percent, but in response to the AHA's strong concerns about this cut, the agency did not implement it in the final rule.

However, CMS continues to have authority to cut hospital payments if they believe the actual increase in hospital payments for FY 2008 and FY 2009 does not correspond to an increase in actual patient severity of illness and was more than the negative adjustments they have already implemented. **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.**

**Physician Supervision of Hospital Outpatient Therapeutic Services.** In the calendar years (CY) 2009 and 2010 outpatient prospective payment system (OPPS) rules, CMS mandated new coverage requirements for "direct supervision" of outpatient therapeutic services. In 2010, CMS' new policy requires that a supervising physician or non-physician practitioner (NPP) be physically present and immediately available at all times when Medicare beneficiaries receive outpatient therapeutic services.

In an environment of continuing shortages of health care professionals, particularly in rural areas, the new, clinically unnecessary requirements will be difficult for hospitals and critical access hospitals (CAHs) to implement and will reduce timely access to services. Hospital outpatient therapeutic services have always been provided by licensed, skilled professionals under the overall direction of a physician and with the assurance of rapid assistance from a team of caregivers, including a physician, should an unforeseen event occur. While hospitals recognize the need for direct supervision for certain outpatient services that pose high risk or are very complex, CMS' new policy will apply to the lowest risk services (such as a simple injections of pain medication) and during night hours when patients are often monitored and not receiving therapeutic services.

In addition, CMS has portrayed significant changes to the policy as a mere "clarification and restatement" of requirements in place since 2001. As a result, hospitals and CAHs find themselves at increased risk for unwarranted enforcement actions, particularly brought by opportunistic whistleblowers claiming that they did not have these precise arrangements in place dating back to 2001.

In a March 2010 communication to Medicare contractors, CMS acknowledged the difficulties that CAHs are having in complying with the new policy and told their contractors not to review or enforce the supervision requirements for CAH outpatient therapeutic services furnished during CY 2010. CMS plans to revisit the issue of supervision for therapeutic services provided to hospital outpatients in CAHs through the annual rulemaking cycle for CY 2011. While this decision is marginally

helpful for CAHs in 2010, serious concerns remain about enforcement for other years and about the potential for whistleblower lawsuits. Further, non-CAH rural and other hospitals are still subject to the onerous and unnecessary policy. **The AHA will work to ensure CMS makes a more fundamental change to the physician supervision policy. A workable solution would:**

- Adopt a default standard of “general supervision” for outpatient therapeutic services, which, according to existing CMS regulations, means “the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure”;
- Establish an exceptions process to identify specific procedures that should be subject to direct supervision. The AHA recognizes that some high risk and/or complex services may benefit from a higher level of supervision. Such an exceptions process should involve recommendations from clinical experts and be subject to notice and comment through a public rulemaking process;
- Ensure that, for CAHs, the definition of “direct supervision” is consistent with the CAH conditions of participation that allow a physician or NPP to present within 30 minutes of being called;
- Permit specified NPPs, in addition to physicians, to provide direct supervision for cardiac rehab, intensive cardiac rehab, pulmonary rehab services and certain outpatient diagnostic services;
- Clarify that direct supervision was never intended when §1861(s)(2)(B) of the *Social Security Act* was added to provide coverage of outpatient hospital services “incident to” the services of a physician; and,
- Prohibit enforcement of CMS’ retroactive reinterpretation that the “direct supervision” requirements applied to services furnished since January 1, 2001.

**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 in teaching hospitals including the greater use of technologies. The AHA is pleased that Congress agreed with our view, and did not call for a reduction in Medicare IME payments to teaching hospitals in the PPACA. In addition, while we support the provision in the PPACA that redistributes unused residency training slots as a way to encourage increased training of primary care

physicians and general surgeons, **we believe that the cap on new residency positions should be lifted. The AHA will continue to push for passage of the Resident Physician Shortage Reduction Act of 2009 (S. 973/H.R. 2251), which would add 15,000 new Medicare-supported, physician-training positions.**

**Post-acute Care.** Inpatient rehab, long term care, skilled nursing and home health all play a critical role in the care continuum. The AHA supports efforts to better coordinate care among the different types of hospitals and post-acute providers, including integrated information systems, a common post-acute patient assessment instrument, care coordination for patients transitioning to post-acute care, payment bundling and accountable care organizations. 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. **The AHA supported a two-year extension to the Long Term Care Hospitals relief on the 25% Rule, short-stay outlier payment cuts and related measures that were originally provided in the *Medicare, Medicaid and SCHIP Extension Act of 2007* and was included in the PPACA.** The AHA also will continue to seek relief from CMS and Congress on the problem of aggressive and inappropriate medical necessity denials by CMS fiscal intermediaries, Medicare Administrative Contractors and Recovery Audit Contractors (RAC).

**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, over 60 percent of rural hospitals 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 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 (RRC) – need to be updated.

The AHA is pleased that Congress included the following legislative relief as part of the PPACA:

- Extended the outpatient hold-harmless payments for certain hospitals in rural areas;
- Created a payment adjustment for low-volume hospitals;
- Ensured that CAHs are paid 101 percent of costs for all outpatient services regardless of the billing methods elected;
- Extended and expanded the Rural Community Hospital Demonstration Program;
- Extended the Medicare Dependent Hospital program for one year;
- Extended the Medicare Rural Hospital Flexibility Program through 2012;

- Extended reasonable cost reimbursement for laboratory services in small rural hospitals; and,
- Reinstated a 3 percent rural home health care add-on.

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;
- Ensure CAHs receive cost-based reimbursement for certified nurse anesthetist services; and,
- Remove unreasonable restrictions on CAHs' ability to rebuild.

**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 is pleased that, under health reform, Congress has expanded eligibility for the discount drug prices available under the program to CAHs and certain SCHs and RRCs, but disappointed the expansion doesn't go far enough. The AHA will continue to work to ensure that the program is expanded to inpatient drugs, for all hospitals, including MDHs and all SCHs and RRCs.

**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. As of January 1, physicians were scheduled to receive a 21 percent cut in their Medicare payments. Congress delayed the implementation of this cut twice this year, most recently in the *Temporary Extension Act of 2010*, which extended the physicians' zero percent update through March 31, 2010, and kept payments equal to their 2009 level. A number of bills working their way through Congress would prevent the 21 percent reduction through September 30 at the latest. **The AHA supports a permanent, long-term replacement to the flawed physician payment formula, and believes this fix should be done in a non budget-neutral manner so that it does not result in reduced payments to other providers. In the interim, legislation should be enacted to prevent any short term cuts to physicians.**

**Recovery Audit Contractors Program.** CMS is currently implementing the permanent RAC program. The prior RAC demonstration program caused significant problems for hospitals in the five demonstration states. Based on that experience, the AHA worked with CMS on many improvements to the permanent RAC program currently wrapping up its first year of implementation. The AHA continues 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; and,
- 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.

*RAC*Trac, an AHA-sponsored, Web-based survey to track the impact of RAC activity on hospitals, started quarterly data collection in early April. AHA created *RAC*Trac to track and summarize the impact of RAC activity on hospitals nationwide. *RAC*Trac is designed to provide timely, reliable data that can be used to advocate for changes to the RAC program going forward.

Concerns raised by the AHA were noted in a recent Government Accountability Office report on the RAC program. The report concluded that CMS has failed to take the appropriate steps to prevent improper Medicare payments, one of the program's primary objectives. Also noted were problems related to the program's contingency fee payment structure, poor oversight of RAC determinations and administrative burden.