AHA Advocacy Alert!

Friday, January 8, 2010

Urge Your Legislators to Support Crucial Changes as House and Senate Health Reform Bills are Reconciled

THE SITUATION

The Senate on December 24 passed its health care reform bill, the "Patient Protection and Affordable Care Act" (H.R. 3590), joining the House, which cleared its reform bill, the "Affordable Health Care for America Act of 2009" (H.R. 3962), in November. The two chambers must now reconcile their bills before voting on final passage. Although conferees have not been officially named, congressional leaders are ironing out the bills' differences.

TODAY'S ACTION

As negotiations unfold, it is critical that the following issues be resolved in the final health care reform bill.

Priorities Impacting All Hospitals

Coverage: The level of coverage offered in the House-passed bill – 96 percent of all those legally residing in the U.S. or 94 percent of all those residing in the country – should be maintained. In addition, coverage should begin in 2013, as envisioned in the House bill, rather than 2014, as proposed in the Senate bill. The final legislation should also include a strong mandate for individuals to obtain coverage, and a strong requirement that employers continue to participate in the provision of health care coverage for their employees.

Medicaid Expansion: Conferees should adopt the Senate health care reform proposal to expand Medicaid eligibility to those at or below 133

percent of poverty, as opposed to the House proposal that expands Medicaid to those up to 150 percent of poverty. We support expanding Medicaid eligibility with federal financing for certain new populations; however, we are very concerned about Medicaid provider payment shortfalls. The Medicaid payment shortfall for hospitals amounted to $10.5 billion in 2008. Medicaid, on average, pays only 89 cents for every dollar spent treating Medicaid patients. To expand Medicaid to even more individuals will exacerbate the already difficult financial situation of many hospitals given the much-below cost rates paid by state Medicaid programs. We also urge the conferees to include the original House funding approach that would provide all states 100 percent federal funds through 2019 for the expanded populations.

Public Option: The final bill should adopt the Senate bill's state-based, non-public, non-governmental health care co-operative approach, which also would create non-public, multi-state health plans. These alternatives offer the needed opportunities for more affordable health plans while preserving market-based approaches with negotiated provider rates. The creation of a public option to compete in the exchange paying rates based in part on Medicare, and potentially open to all individuals, as well as small and large businesses, would put tremendous pressure on provider payment rates and would only exacerbate the underpayment of hospitals.

Hospital Payment Updates: Hospital market basket reductions in 2010 through 2013 should be minimized unless coverage is extended in those years. We strongly support the Senate approach to market basket update reductions for 2010 and 2011, which would reduce the updates by 0.25 percentage point in each year, rather than the larger cuts in the House bill. Beyond 2011, both the House and Senate bills propose to reduce the annual market basket update permanently by a measure of productivity growth in the general economy, generating billions in savings. The Senate market basket reductions consist of productivity measures beginning in 2012, and added reductions of 0.1 percentage point in 2012 and 2013 and 0.2 percentage points in 2014 through 2019. The House bill applies productivity cuts to the hospital market basket update starting in 2010 – an estimated reduction of 1.3 percent each year. We oppose the permanent annual productivity reductions in the Senate and House bills, and strongly urge the conferees to sunset the productivity adjustments after 2019, the end of the 10-year budget period.

Readmissions: We strongly disagree with the House and Senate approaches, similar policies that would impose financial penalties for so-called "excess" readmissions when compared to "expected" levels of readmissions**.** A policy to reduce readmissions should address only *avoidable* and unplanned hospital readmissions related to the original admission. The current proposals do not distinguish between readmissions that are planned and represent good care; readmissions that are not planned and unrelated to the original reason for admission; and readmissions that are not planned but are related to the original admission. Both provisions need to be amended to reflect these principles.

Hospital-Acquired Conditions (HACs): Conferees should reject the provision in the Senate bill that would add a 1 percentage penalty to hospitals in the upper quartile of rates of HACs. Congress previously adopted policies that prohibit assigning a patient to a higher-paying DRG when the reason for that assignment was a preventable complication associated with a misstep in care during the hospitalization. These policies already provide financial incentives for hospitals to reduce hospital-acquired infections, falls and other potentially preventable complications in care.

Independent Payment Advisory Board (IPAB): While we appreciate the Senate excluding hospitals from IPAB through 2019, the creation of any new advisory board, such as the one proposed in the Senate bill, which would make binding recommendations on Medicare payment policy, should be dropped from the bill. Such a board minimizes Congress's role in ensuring adequate Medicare payments.

Medical Device Tax: Conferees should adopt the Senate approach on medical device "taxes" or fees. The Senate provision will make it more difficult for device manufacturers to easily pass the "fee" on to hospitals and better ensure that device manufacturers contribute to the nation's goal of expanding coverage to more Americans. We support the House provision's effective date of 2013.

Medicaid FMAP Extension: Conferees should include the House provision to extend the *American Reinvestment and Recovery Act* (ARRA) temporary FMAP increase for an additional six months through June 2011.

Priorities Impacting Certain Types of Hospitals

Medicare and Medicaid Disproportionate Share Hospital (DSH) Payments: A combination of Senate and House approaches should be taken with respect to DSH payment reductions. First, it is imperative that no reductions take place until a threshold trigger of 50 percent improvement in a state's insurance coverage is met, as outlined in the Senate bill. The final bill should include the House savings number of $10 billion for Medicaid DSH and $10 billion for Medicare DSH over the period beginning on January 1, 2017 through FY 2019 and the later date of 2017 for the commencement of any DSH reductions. The Senate approach to achieving those reductions in Medicaid DSH by not providing the Secretary of the Department of Health and Human Services with the authority to change the current program, but by simply taking the reductions from the already established state DSH allotments, also should be adopted.

340B Program Expansion: The Senate provision to expand 340B discounts to include inpatient drugs should be adopted. Both the House and Senate bills expand the 340B drug discount program, but the Senate bill expands the discounts to cover not only outpatient pharmaceuticals, but also inpatient pharmaceuticals for existing 340B program participants. The Senate bill also would expand 340B eligibility (for both outpatient and inpatient drugs) to certain Rural Referral Centers (RRCs) and Sole Community Hospitals (SCHs) with DSH adjustments at 8 percent or higher, Critical Access Hospital (CAHs), freestanding children's hospitals, and freestanding cancer hospitals. In addition, while the Senate provisions expanding eligibility to additional hospitals should be adopted, we prefer the hospital expansion provisions in the House bill that cover more rural hospitals, including Medicare-Dependent Hospitals (MDHs).

Long-Term Care Hospitals (LTCHs): The Senate provision that extends for two years selected LTCH provisions in the *Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)* should be adopted. These provisions would further delay full implementation of the 25 percent rule, the short-stay outlier cut, and the one-time budget-neutrality adjustment planned by CMS. The current moratorium on new LTCH beds and facilities, with exceptions, also would be extended.

Accountable Care Organization (ACO) Structure: The Senate provision that allows hospitals, in cooperation with physicians, to provide leadership

in an ACO should be adopted. In addition, the House approach of creating ACO *pilots* instead of an ACO *program*, as proposed in the Senate bill, should be adopted. Establishing a pilot allows for testing and evaluation before a program is established.

Physician Self-Referral: Conferees should adopt the House bill's trigger date for grandfathering existing physician-owned facilities. Both the House and Senate bills would eliminate the exception for new physician-owned hospitals under the Stark law for self-referral and grandfather existing physician-owned hospitals, with requirements for disclosure of financial interests to patients and the public, requirements to ensure bona fide investments and management of conflicts of interest, and limitations on the growth of grandfathered facilities. The House bill grandfathers those facilities certified to participate in Medicare on or before January 1, 2009, while the Senate bill grandfathers those facilities certified by August 1, 2010. An earlier grandfathering date will ensure that the problems associated with physician self-referrals to hospitals are contained as much as possible.

Rural Provisions: The House two-year extension for certain existing rural programs should be adopted. The Senate provisions to help sustain and improve access to care in rural areas should be included in the final conference report**.** They include: improvements in the payment adjustment for low-volume hospitals; a demonstration project on community health integration models; a MedPAC report on Medicare payment adequacy to rural providers; assurances that CAHs are paid 101 percent of costs for all outpatient services they provide, regardless of the billing method elected; a rural community hospital demonstration program; an extension of the MDH program for one year; the extension of the Medicare Rural Hospital Flexibility Program through 2012; and reasonable cost reimbursement for laboratory services in small rural hospitals.

This *Alert* does not include all of the issues we currently are working on. Please refer to the attached 27-page letter, which was sent to congressional leaders this week and captures all of our mutual concerns.

HOW YOU CAN HELP

We need your help to ensure that these issues are addressed in a way that helps you continue to take care of patients and serve your community.

Please urge your party's leaders to include these changes as they reconcile the House and Senate bills. Depending on your relationship with your legislators, please call them personally - or their chief of staff or legislative assistant who handles health care issues - and convey the messages outlined above. Please call 202-224-3121 and ask to be connected to your legislators' offices.

(Call 1-877-242-2240 or e-mail AHAadvocacy@aha.org
to let us know how your Hill contacts go … thanks!)

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January 7, 2010

The Honorable Nancy Pelosi
Speaker of the House
U.S. Capitol
Washington, DC 20515

The Honorable Harry Reid
Majority Leader, U.S. Senate
U.S. Capitol
Washington, DC 20510

Dear Speaker Pelosi and Majority Leader Reid:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, as you work to reach agreement on a conference report for health care reform legislation, the American Hospital Association (AHA) wishes to offer our preferences, suggestions and comments on a number of proposals in the House and Senate bills. The AHA and its members have been active participants in efforts to expand coverage to millions of individuals and reform the health care delivery system and commend you on your efforts thus far.

The first portion of this letter comments on each bill's coverage proposals. Our observations on each bill's policies affecting hospital payments follow.

COVERAGE

The AHA is pleased that both bills offer expanded health coverage to millions of Americans. However, we maintain that if coverage cannot be offered at least at the level of the House bill, then hospitals' contribution to financing health care reform in the form of payment cuts should be reduced.

We urge conferees to maintain the level of coverage offered in the House-passed bill. In addition, we strongly support beginning coverage in 2013, as envisioned in the House bill. As hospitals, we have long sought universal coverage for health care services and applaud your attempts to reform the system in a way that provides coverage to as many people as possible. We particularly applaud the House proposal that expands coverage to 36 million people (96 percent of all those legally residing in the U.S. or 94 percent of all those residing in the country). Such coverage is achieved through strong individual and employer mandates. At the same time, the Senate-passed bill does not cover as many uninsured individuals: 94 percent of all uninsured (excluding

unauthorized immigrants) or 92 percent of all U.S. residents. Under the Senate proposal, at the end of the 10-year period, in 2019, there will still be 23 million uninsured according to the Congressional Budget Office (CBO). The House proposal would cover 5 million additional uninsured people, leaving 18 million uninsured in 2019.

SHARED RESPONSIBILITY

The AHA has long advocated for coverage for all, paid for by all, as embodied in our multi-year health care reform initiative known as *Health for Life.* Shared responsibility of individuals and employers is critical to achieving coverage for all.

To ensure that an individual coverage mandate is meaningful, it will be important that insurance market reforms are not only thorough but also implemented rapidly. Such a mandate would be greatly enhanced by a robust national health insurance exchange with a broad scope of authority that includes regulating health plans. Subsidies for low-income individuals, as well as certain expansions in Medicaid eligibility, are critical to ensure those low-income populations, long ill-served by the current insurance market, will have access to affordable coverage.

The AHA urges the conferees to make certain the final legislation balances a mandate for individuals to obtain coverage with a strong requirement that employers continue to participate in the provision of health care coverage for their employees. We support an employer mandate that provides strong incentives for employers to continue their historical role in providing health insurance to their employees.

Individual mandate. **We believe that the House bill, in terms of the individual mandate, holds the greater promise for creating a balance between individuals and employer responsibility.** The House bill provides a strong individual mandate tied to 2.5 percent of modified adjusted gross income, with limits and appropriate exceptions for certain individuals; while the Senate bill includes a tax penalty of $95 in 2014, rising to $750 in 2016.

Employer mandate. **We believe the House bill offers a robust framework in urging employers to maintain their participation in the health insurance system.** While employers have served as the backbone of our health care insurance system, voluntarily providing health insurance to U.S. workers and their families for more than half a century, the AHA believes they should continue their responsibility for advancing health care coverage reform. Employers that do not participate in providing coverage should be assessed a penalty, which would be used to support the programs through which their employees obtain health care coverage.

IMMEDIATE INSURANCE MARKET REFORMS

The AHA strongly believes that the following insurance market reforms should be addressed immediately:

- Guaranteed issue of coverage.
- Renewability of issued coverage.
- Prohibitions on pre-existing condition exclusions.
- Prohibition on rescissions of coverage.
- Prohibition of lifetime and annual limits.
- Limitations on premium rating bands.
- Prohibition on excessive waiting periods.
- Health plan medical loss ratio requirements.

Reforming the insurance market for both the individual and group markets is essential to meaningful health care reform. While covering the uninsured is a crucial element of health reform, it also is critical that already insured people are able to keep their coverage. Insurance market reform is the area where the greatest consensus lies.

The AHA urges the conferees to adopt the earlier implementation dates in the House proposal for these needed reforms. The House health bill addresses these reforms and puts them in place, in general, by 2010. The Senate health bill staggers the implementation of these insurance reforms, with the major reforms – such as prohibitions on pre-existing conditions and lifetime and annual limits – not implemented until 2014. Immediate implementation of these critical reforms will help address the immediate health coverage needs of millions of Americans.

The AHA also supports the Senate proposal to prohibit insurers from dropping coverage when an individual chooses to participate in a clinical trial and to require the insurer to cover routine care costs associated with the clinical trial. Clinical trials are the most important tool science has in exploring the feasibility and efficacy of new treatment methods, drugs, and devices. They are essential to advancing our knowledge of how to care for patients effectively and safely, and in making the much needed changes in coverage, the opportunity to conduct clinical trials should not be endangered.

PUBLIC PLAN OPTION

The AHA strongly recommends that the conferees adopt the approach taken in the Senate health care reform bill, which would create state-based, non-public, non-governmental health care co-operatives and non-public, multi-state health plans. These alternatives offer the needed opportunities for more affordable health plans while preserving market-based approaches with negotiated provider rates.

The creation of a public option to compete in the exchange, potentially open to all individuals, as well as small and large businesses, would put tremendous pressure on provider payment rates, even if the plan paid negotiated rates within a corridor of

aggregate average Medicare rates and private-pay rates, as included in the House bill. This would only exacerbate the underpayment of hospitals by the other major public programs – Medicare and Medicaid. The combined underpayment for the hospital services provided to Medicare and Medicaid beneficiaries was $32.4 billion in 2008. This comes at a time when hospitals are being asked to do more – responding to the threat of H1N1 virus in their communities, providing care for higher numbers of the uninsured, keeping up with the latest technologies, and dealing with a significant workforce shortage.

HEALTH INSURANCE EXCHANGES

The AHA supports the creation of health insurance exchanges as mechanisms for consumers to choose health plans that fit their needs. The health insurance exchanges in both the House and Senate bills serve the same purpose: to create a new marketplace for affordable coverage. The exchanges can provide greater access, pool risk and manage important assistance for the purchase of insurance, such as public subsidies.

The AHA urges the conferees to restructure the exchanges to include greater plan oversight and risk management responsibilities, and limit the grandfathering of any existing plans so that insurance reform applies to all insurance policies sold in this country, inside or outside of the exchange. It is critical that the insurance rules governing plans within the exchange are the same as the insurance rules governing plans outside of the exchange.

The AHA supports the approach adopted by the House regarding the federal role of the exchange and the limited grandfathering of existing plans to comply with the key insurance reforms mentioned above. In addition, the AHA supports the House approach that allows all individuals, regardless of status, the opportunity to purchase coverage through the exchange. Structured enrollment periods, risk adjustment across plans and transparent management of the public subsidies are much-needed elements within the exchange to avoid adverse selection and market segmentation. The House bill accomplishes these steps by creating a federal exchange program and allowing existing health plans that are grandfathered a five-year period in which to come into compliance with insurance reforms. While the AHA supports the creation of state-based co-operatives and multi-state, non-public health plans, the Senate's state-based insurance exchange approach lacks the leverage and authority to provide the insurance market oversight needed in a health care reform environment. The federal exchange in the House bill, coupled with the non-governmental, state-based insurance co-operatives, is the preferred approach.

The AHA supports the adoption of the House provision that partially repeals the exemption from the antitrust laws established under the *McCarran-Ferguson Act* for health and medical malpractice insurers. The *McCarran-Ferguson Act* exempts from federal antitrust laws most anti-competitive activities of health and other insurers, including price fixing, bid rigging and market division activities. This repeal would

subject health insurers to the same standard of competitive conduct expected of others in the health care field. Allowing insurers to engage in anti-competitive conduct without recourse to the antitrust laws could undermine the success of the health exchanges, as there would be no federal antitrust bar to health insurers segmenting the health exchange markets in which they compete or fixing at artificially high rates the prices charged to consumers within the exchanges. The antitrust exemption is replaced with certain protections for medical malpractice insurers.

ADMINISTRATIVE SIMPLIFICATION

The AHA supports the Senate bill's approach to administrative simplification because of the broader and more comprehensive scope of administrative functions being simplified, improvements to the transparency and public input process for development of new standards and operating rules, and inclusion of a process for periodic assessment of new areas where further standardization would be valuable. Both the House and Senate bills include substantial provisions related to achieving greater simplification and cost reduction in the administrative requirements associated with health insurance and related programs – changes that will benefit enrollees, providers and health plans alike. We commend both chambers for their support, and for building on the HIPAA transaction standards process to expand these efforts, which has the broadest reach to different health plans and programs. We particularly support the Senate's provision to evaluate periodically other areas where simplification should occur.

MEDICAL REIMBURSEMENT DATA CENTER

The AHA urges the conferees to ensure that efforts to increase hospital price transparency maintain the proprietary nature of per-service payments negotiated between hospitals and insurers. The Senate bill creates a center that would develop fee schedules and other database tools that fairly and accurately reflect market rates for medical services and the geographic differences in those rates. The center would use statistical and data processing technology to develop the fee schedules and update the rates regularly. The center would make health care cost information readily available to the public through an Internet Web site that allows consumers to understand the amounts that health care providers in their area charge for particular medical services.

The AHA supports state-based transparency approaches to provide hospital charge and quality information by service. However, efforts to reveal negotiated payment rates between individual hospitals and insurers would not provide relevant information to consumers. Consumers need information on their individual co-pays, deductibles and other out-of-pocket costs, and we urge the conferees to require plans to provide this information to patients.

MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) COVERAGE AND PAYMENT

MEDICAID EXPANSION AND PROGRAM PAYMENTS

The AHA urges the conferees to adopt the Senate health care reform proposal to expand Medicaid eligibility to those at or below 133 percent of poverty, as opposed to the House proposal that expands Medicaid to those up to 150 percent of poverty. We support expanding Medicaid eligibility with federal financing for certain new populations. As the program is expanded, however, we are very concerned about Medicaid provider payment shortfalls. The Medicaid payment shortfall for hospitals amounted to $10.5 billion in 2008. Medicaid, on average, pays only 89 cents for every dollar spent treating Medicaid patients. To expand Medicaid to even more individuals will exacerbate the already difficult financial situation of many hospitals given the much-below cost rates paid by state Medicaid programs.

The AHA urges the conferees to include the original House funding approach that would provide all states 100 percent federal funds through 2019 for the expanded populations. In addition, the AHA supports the House approach that would give states that have already expanded their Medicaid programs prior to the enactment of health care reform the same enhanced Federal Medical Assistance Percentages (FMAP) for these same populations. The mandate to expand the Medicaid program should come with additional federal funds, particularly as many states are still struggling to balance budgets with the reduced revenues resulting from the economic downturn. **We also urge adoption of the House provision to extend the *American Reinvestment and Recovery Act* (ARRA) temporary FMAP increase for an additional six months.**

The AHA has long supported Medicaid provider payment protections, including during the debate on the economic stimulus legislation earlier this year. The expansion of Medicaid will come as many state budgets will still be reeling from the effects of the economic downturn, with many states choosing to reduce Medicaid payment rates to hospitals and other providers to address budget gaps.

The AHA supports the various transparency-related provisions in the House proposal that would require states to report on payment methodologies and rates for hospitals and other providers and would urge the conferees to look at expanding the provider payment protections for hospitals and other providers. In addition, the AHA supports the House provision that recognizes payments for the costs of graduate medical education, in and outside the hospital, as legitimate Medicaid payments.

MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM

The Medicaid DSH program is our nation's primary source of support for safety-net hospitals that serve the most vulnerable populations – Medicaid beneficiaries, the uninsured and the underinsured. Many hospitals rely on Medicaid DSH payments to be

able to keep their doors open. These funds go toward supporting a broad range of services for uninsured or underinsured children and adults – such as chronic disease management, preventive care, dental care and child abuse screening. Medicaid DSH funds help support essential community services, such as trauma and burn care, pediatric intensive care, high-risk neonatal care and emergency psychiatric services. Such resources also help fund hospital readiness for natural and man-made disasters.

The AHA urges the conferees to accept a combination of Senate and House approaches with respect to Medicaid DSH payment reductions. Specifically, we urge conferees to accept the House savings number of $10 billion over the period beginning on January 1, 2017 through FY 2019. We also urge the conferees to use the later date of 2017, as found in the House bill, for the commencement of DSH reductions. It is imperative that no reductions take place until a threshold trigger of 50 percent improvement in a state's insurance coverage is met, as outlined in the Senate bill. The AHA also urges the conferees to accept the Senate approach to achieving those reductions by not providing the Secretary of the Department of Health and Human Services (HHS) with the authority to change the current program, but by simply taking the reductions from the already established state DSH allotments. We also urge the conferees to adopt the DSH allotment floor that would limit any reduction in state DSH allotments to 50 percent of FY 2012 allotments as found in the Senate bill.

With between 92 and 94 percent coverage of individuals residing in the U.S. by FY 2019 projected by the CBO for either bill, we know universal coverage will not be fully achieved. Populations will remain uncovered, and hospitals will be asked to provide their health care and essential community services. The need for a strong safety net, with a robust Medicaid (and Medicare) DSH program will still be needed to catch those who will "fall through the cracks."

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

The AHA supports the House approach to terminate the CHIP program in 2013, the first year of the health insurance exchange. The AHA believes that this population will be better served in a robust exchange as long as there are adequate subsidies to support the purchase of coverage and accommodations, such as a Medicaid wrap-around benefit, to provide needed services for this population not otherwise available through the exchange plans.

MEDICARE PAYMENT

PRODUCTIVITY ADJUSTMENTS TO ANNUAL MARKET BASKET UPDATES

Nearly half of the Medicare savings in the House and Senate bills are created by reducing annual market basket updates for hospitals and other providers over the 10-year period. While the hospital field recognizes that it will make a contribution toward financing health care reform, hospital payment reductions should coincide with coverage

expansions to the greatest extent possible. This means that larger reductions in the market basket update should not occur until coverage is expanded in 2013, as in the House bill, or 2014, as in the Senate bill.

The AHA urges the conferees to minimize the hospital market basket reductions in 2010 through 2013 unless coverage is extended in those years. The House bill applies a full productivity reduction in calendar years 2010 through 2012, years in which coverage is not expanded. The Senate bill applies a full productivity reduction and adds a 0.1 percentage point reduction to productivity in both 2012 and 2013, years in which coverage is not expanded. In that bill, coverage is expanded in 2014. The House bill begins productivity cuts in 2010, and does not expand coverage until 2013.

The AHA strongly supports the Senate approach to market basket update reductions for 2010 and 2011, which would reduce the updates by 0.25 percentage point in each year. The House-passed bill contains much larger reductions to the market basket update: approximately 1.3 percentage points in 2010 and 2011. Hospitals are keenly aware that their payments will likely be reduced in 2011 and beyond to account for alleged changes in coding and documentation that the Centers for Medicare & Medicaid Services (CMS) claims may have occurred as a result of the adoption of the new MS-DRG classification system. With average Medicare margins projected to be negative 5.9 percent in FY 2010 according to the Medicare Payment Advisory Commission (MedPAC), hospitals cannot withstand large reductions in the updates in 2010 and 2011, or additional regulatory downward adjustments.

Beyond 2011, both the House and Senate bills propose to reduce the annual market basket update permanently by a measure of productivity growth in the general economy, generating billions in savings. The Senate market basket reductions consist of productivity measures beginning in 2012, and added reductions of 0.1 percentage point in 2012 and 2013 and 0.2 percentage points in 2014 through 2019. The House bill applies productivity cuts to the hospital market basket update starting in 2010 – an estimated reduction of 1.3 percent each year.

The AHA opposes the permanent annual productivity reductions in the Senate and House bills, and strongly urges the conferees to sunset the productivity adjustments after 2019, the end of the 10-year budget period. A sunset of the productivity adjustments would have no budgetary cost associated with it within the 10-year budget window. Incorporating permanent reductions for productivity set up unrealistic expectations for improved efficiency that may create access barriers for America's seniors. CMS' Office of the Actuary, in its analysis of the House and Senate bills, acknowledged the extreme pressure a permanent productivity offset would have on hospitals and other providers, stating that "reductions in payment updates to institutional

providers, based on economy-wide productivity gains, are unlikely to be sustainable on a permanent annual basis."[1]

The AHA supports a floor of zero percent on the annual inflation update, as provided in the House bill, so that no hospital can receive a negative update (less than zero) due to the combination of the productivity adjustment, the Senate's additional 0.1 and 0.2 percentage point reductions to the update and the additional reductions for not reporting quality measures and/or incurring penalties for not being a "meaningful user" of health information technology (HIT). We are very concerned that the Senate proposal allows hospital updates to fall below zero, thereby creating a potential situation where a hospital could receive a negative update as a result of update penalties for non-reporting of quality data and/or HIT penalties.

MEDICARE DSH PROGRAM

The AHA supports the provision in the House bill that includes DSH payment reductions of no more than $10 billion in FYs 2017 through 2019. Like the Medicaid DSH program, the Medicare DSH program supports hospitals treating a disproportionate share of Medicare's poorest beneficiaries and Medicaid patients. With between 18 million and 23 million people still estimated to be uninsured in 2019, maintaining a strong Medicare DSH program is important as hospitals continue to be the safety net for the uninsured.

We are disappointed that the final Senate-passed bill increased the amount of Medicare DSH savings from $20.6 to $24.4 billion. In the absence of further coverage expansions, the current Senate provision to implement $24.4 billion in DSH cuts is overly aggressive.

READMISSIONS

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 House and Senate approaches, similar policies that would impose financial penalties for so-called "excess" readmissions when compared to "expected" levels of readmissions. We recognize that the payment system should not financially reward hospitals for failure to prevent readmissions that could have been avoided by appropriate action of the hospital and its medical staff. The AHA, however, is very concerned about proposals to reduce readmissions that do not distinguish among readmissions that are planned and represent good care; readmissions that are not planned and unrelated to the original reason for admission; and readmissions that are not planned but are related to the original admission.

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[1] Estimated Financial Effects of the *America's Affordable Health Choices Act of 2009* (H.R. 3962), as passed by the House on November 7, 2009. CMS Office of the Actuary. November 13, 2009.

The AHA supports the Senate bill's elimination of readmissions measures from the value-based purchasing (VBP) system. A separate readmissions policy and a VBP program that includes readmissions measures are duplicative and could penalize some hospitals twice for the same reason. The House bill allows CMS to include the readmissions measures reported on the *Hospital Compare* Web site in the VBP program, thus creating a double jeopardy for hospitals. The Senate bill precludes this double jeopardy by prohibiting the HHS Secretary from including readmissions in the VBP program.

The AHA supports offering transitional care funding to a wide variety of hospitals with high readmissions rates: from hospitals with high DSH patient percentages as called for in the House bill, to rural and small community hospitals, as noted in the Senate bill. Under both the House and Senate proposals, hospitals offering special services that care for patients with underlying medical conditions that are likely to require readmission, and hospitals that serve patient populations with inadequate access to follow-on care, particularly public hospitals, will most likely suffer penalties, putting them at an unfair disadvantage. Both bills provide funding to assist hospitals in support of transitional care activities that could help lower their readmissions rates. The AHA prefers the House version of this fund, as it would be available only to hospitals, while the Senate proposal allows non-hospital, community-based organizations to participate in the pilot program.

The AHA believes that penalties should be applied only to the readmissions associated with the three conditions included in the Senate and House policies, and we believe the penalty should be smaller than what is mandated in either bill. Under both current bills, hospitals' actual readmission rates would be compared to their expected readmission rates for the three conditions (heart attack, heart failure and pneumonia), and any hospital with even one readmission more than expected would be financially penalized. Penalties would be significant because they would be applied to every single Medicare discharge. The maximum reduction in the Senate bill is 3 percent, while the House bill's penalty grows to 5 percent.

We believe there are three other significant actions that could be taken to create a more reasonable approach to reducing readmissions. First, the final bill should require the exclusion of patients awaiting transplants, or with diagnoses of end-stage renal disease, burns, trauma, metastatic cancer, or serious mental illness or substance abuse. Second, the proposal should be altered to enable hospitals that attain an acceptable level of performance on readmissions, or that achieve significant improvements in readmissions, to escape penalty in a manner similar to the method proposed for VBP program. Third, hospitals that choose to participate in other delivery reform programs that provide financial incentives for improved patient-centered performance across the care continuum, such as payment bundling, accountable care organizations, medical homes or other programs crafted by the envisioned Medicare Innovations Center, should be

exempted from this payment penalty and subject only to the payment incentives or disincentives contained in the program of which they become a part.

Finally, **hospitals should not be required to collect and submit all-payer data as proposed in the Senate bill, but perhaps insurers participating in the insurance exchanges should be encouraged to do so.** The Senate bill calls on hospitals to submit all-payer data so that CMS can calculate all-payer 30-day readmission rates in the same manner it currently calculates Medicare readmission rates. While the notion of having all-payer readmission rates is appealing, hospitals do not have the required data for all payers. The methodology used by CMS requires billing data from all patient encounters for the 24 months preceding the admission, including claims data from physicians' offices, surgi-centers, dialysis facilities and other hospitals not affiliated with the hospital to which the patient was admitted. Not only do hospitals not have these data, they have no way of knowing what the universe of other providers from whom they would need to solicit such information would be, and they likely would not have agreements in place with many of these other providers to enable them to get the relevant data without violating HIPAA rules. The only organizations with these data are the patients' insurers, and even they may not have all of the requisite data.

INDEPENDENT PAYMENT ADVISORY BOARD

The AHA strongly opposes the creation of any new advisory board that would make binding recommendations on Medicare payment policy. We support the House in rejecting a similar board in its bill because it minimizes Congress's role in ensuring adequate Medicare payments. The Senate bill creates a new Independent Payment Advisory Board (IPAB) that would make binding recommendations on Medicare payment policy, and make non-binding recommendations for changes in private payer payments to providers as well.

Hospitals, which already lose money on average treating Medicare beneficiaries, have payment updates that are reduced by more than productivity in eight of the 10 years covered by the Senate bill, and are thereby exempted from the binding recommendations of the board in those years. **We commend the Senate for this provision.** Additional recommendations to reduce Medicare payments to hospitals are unnecessary, and any new board or commission should not be able to make "fast-track" recommendations to Congress with additional hospital payment reductions. If this proposal is adopted, hospitals, including critical access hospitals (CAHs), should be permanently exempt from IPAB's scope of review.

CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMI)

The AHA supports the creation of this new center to test models and expand those that are most promising; however, participation in new models and expansions must be on a voluntary basis. CMS should be restricted from making extensive payment changes that *require* additional hospital participation (or penalize non-participating hospitals) without congressional approval.

VALUE-BASED PURCHASING (VBP)

The AHA supports tying quality measurement to performance-based hospital payment in a VBP program as long as it is implemented in a budget neutral manner. Any VBP program should include only measures that have been held to the standard, manner and form of those measures that are reported, for a minimum of one year, on the *Hospital Compare* Web site. We commend the Senate for removing the readmissions measures from VBP in the Manager's Amendment, which would have penalized hospitals multiple times across different provisions. The AHA supports the development of hospital efficiency measures that account for beneficiary characteristics including age, race, severity of illness and other factors the HHS Secretary deems appropriate, and believes that adjustments also must be made to account for public policies, such as payments for medical education, caring for a disproportionate share of poor patients and other such factors. We look forward to collaborating with the HHS Secretary on the timing of including hospital efficiency measures to ensure the necessary standards are met, prior to implementation in VBP.

We commend the Senate for recognizing that VBP must reward both achievement and improvement on quality measures. Further, we applaud the Senate for noting that minimum performance standards are counterintuitive to real quality improvement. The AHA looks forward to collaborating with the HHS Secretary on measurement decisions, including how the measures currently reported on *Hospital Compare* should be weighted and composited to generate a hospital's performance score. We concur with the Senate for including VBP demonstrations for exempt hospitals, such as CAHs, and those hospitals that do not meet minimum measurement thresholds.

NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING

The AHA supports incremental approaches that test different models of bundling payments to improve coordination of care. However, an appropriate evaluation is essential to determine what works and what does not before broad adoption. Both the Senate and House bills require CMS to develop and test models that would bundle Medicare payment across provider settings and payment systems. The House bill accomplishes this by expanding the current Acute Care Episode (ACE) demonstration program. The House bill also requires CMS to develop a plan to reform Medicare payment for post-acute care services.

We support the more flexible House bill language that would encourage a wide 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. The Senate bill requires that the pilot program bundle include inpatient, outpatient, physician and post-acute services. The Senate bill defines as eligible for the voluntary pilot program entities that are comprised of groups of providers, including a hospital, a physician group, a skilled nursing facility and a home health agency. The AHA recommends that the Senate bill language be modified in a way that provides more flexibility as to what an "eligible entity" is so that the most appropriate

organization or combination of organizations can be brought together based on the type of bundle being tested. The language should specify that all types of hospitals – acute care, inpatient rehabilitation facilities, long-term care hospitals, psychiatric facilities, cancer, children's, CAHs and new continuing care hospitals, created in both bills – should be allowed to participate in pilots.

The AHA supports the HHS Secretary's ability to expand and extend successful bundling models, as long as hospital participation continues to be voluntary. Both bills give the HHS Secretary authority to expand and extend bundling pilots if they are found to reduce costs while improving or maintaining quality. America's hospitals vary in their ability to accept the additional risk of bundled payments because of differences in physician relationships, access to post-acute services, the types of patients served and financial status. Any broad-scale requirement for participation should be discussed and determined at the congressional level.

In addition, any bundling provision should specify that the HHS Secretary waive for the pilot program antitrust, anti-kickback, civil monetary penalties, Title XI general, peer review, and administrative provisions, and other provisions that create barriers to clinical integration as necessary. Both bills generally state that the Secretary would have the authority to waive statutory provisions, as necessary, to carry out the pilot program, but do not clearly delineate or specify what provisions would require waivers. Further, specific language should be added that gives the Secretary authority to waive Medicare regulations where appropriate, such as the skilled nursing facility three-day stay rule, the 60 percent rule for inpatient rehabilitation facilities, and the LTCH 25 percent rule. Additionally, standards used to determine reasonable and necessary medical requirements for various services also should be modified or waived altogether. It is unclear whether the bills provide the Secretary with this authority.

ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

The AHA supports the Senate provision that allows hospitals, in cooperation with physicians, to provide leadership in an ACO. Both bills allow the HHS Secretary to establish voluntary ACOs, which would be responsible for managing the care of certain beneficiaries, and allow the Secretary to share some of the savings from improved care management with providers. While there are differences between the House and Senate approaches, both would allow partial capitation and other payment incentives to improve care management. Both bills also rely on significant physician involvement and leadership; however, the Senate bill allows physician participation to occur under the umbrella of a hospital organization.

The AHA supports the House approach of creating ACO *pilots* instead of an ACO *program* as proposed in the Senate bill. Establishing a pilot allows for testing and evaluation before a program is established.

The AHA supports the Secretary's ability to expand and extend successful ACO models, as long as hospital and physician participation continues to be voluntary. The House bill gives the Secretary authority to expand and extend the voluntary ACO pilots if they are found to reduce costs while improving or maintaining quality. America's hospitals vary in their ability to accept additional risk payments beyond traditional fee-for-service payments because of differences in physician relationships, access to post-acute services, types of patients served and financial status. Any broad-scale requirement for participation should be debated and determined at the congressional level through the established legislative process.

In addition, as with bundling, any ACO provision should specify that the Secretary waive for the pilot program antitrust, anti-kickback, civil monetary penalties, Title XI general, peer review, and administrative provisions, and other provisions that create barriers to clinical integration as necessary. Both bills generally state that the Secretary would have the authority to waive statutory provisions as necessary to carry out the pilot program, but do not clearly delineate or specify what provisions would require waivers. Further, specific language should be added that gives the Secretary authority to waive Medicare regulations where appropriate, such as the skilled nursing facility three-day stay rule, the 60 percent rule for inpatient rehabilitation facilities, and the LTCH 25 percent rule. It is unclear whether the bills provide the Secretary with this authority.

GEOGRAPHIC VARIATION

The AHA appreciates the $8 billion in additional funding provided in the House bill for two Institute of Medicine (IOM) studies designed to look at geographic variation in Medicare spending and value, but we are very concerned about the redistributional impact in FY 2014 and beyond. The first study would require a report and recommendations to improve the accuracy of the geographic adjustment factors for hospitals and physicians (area wage index and geographic practice cost index) and would provide the HHS Secretary with $4 billion per year in FYs 2012 and 2013 to propose and implement changes. However, beginning in FY 2014, those changes in geographic adjusters would become budget neutral and significantly redistribute funding across the country.

The AHA believes that the Senate's VBP proposal, which includes an additional new measure of total Medicare spending per capita (adjusted for DSH, medical education, outliers and special rural payment add-ons) as well as efficiency measures, is a more appropriate approach than the second IOM study (described below) to improve value in the Medicare program, and is preferable to allowing the HHS Secretary to make major changes in payment policy. The inclusion of efficiency measures in a VBP system will offer opportunities to reward hospitals that provide patient care in a cost effective manner. The second IOM study would evaluate growth in volume and intensity of services and spending and requires IOM to make recommendations to address the variation in Medicare spending per-capita (not including payments for graduate medical education, DSH and HIT). Within eight months

of the report, the HHS Secretary would be required to submit a plan to Congress that would reduce expenditures by modifying Medicare payments for hospitals, including CAHs and other providers, through the creation of a new "value index." Unless Congress enacts a joint resolution in opposition to the recommendations in the Secretary's plan by May 31, 2012, the Secretary is directed to propose these recommendations through rulemaking.

HOSPITAL-ACQUIRED CONDITIONS (HACS)/ INFECTIONS

The AHA urges Congress to reject the provision in the Senate bill that would add a 1 percentage penalty to hospitals in the upper quartile of rates of HACs. The AHA and its member hospitals agree that patients and their insurers should not expect to pay for the additional costs resulting from an error in care. Hospital-acquired infections and other complications in care are important quality improvement opportunities and must be addressed by hospitals and other providers. Congress previously adopted policies that prohibit assigning a patient to a higher-paying diagnosis-related group (DRG) when the reason for that assignment was a preventable complication associated with a misstep in care during the hospitalization. These policies provide financial incentives for hospitals to reduce hospital-acquired infections, falls and other potentially preventable complications in care.

The House bill would augment existing policy by requiring reporting of hospital-acquired infection data through the Centers for Disease Control and Prevention's (CDC) national infection database. The Senate bill expands on the current Medicare policy in four ways by:

1. requiring Medicaid programs to prevent HACs from leading to higher-paying DRGs;
2. including infection rates in VBP;
3. establishing a new HAC provision that would penalize hospitals with HAC rates in the top quartile across the country by reducing their total Medicare payments by 1 percent; and
4. requiring public reporting of the HAC data collected by CMS during implementation of the original HAC policy.

The AHA believes that current policies to prohibit payment in a higher-paying DRG couples with the inclusion of infection rates in a VBP system obviate the need for a 1 percent penalty applied to hospitals in the upper quartile of HAC rates. We believe the most effective method of aligning incentives with the imperative to reduce infections and other complications would be to include infection rates in VBP, as included in the Senate bill, which rewards both appropriate levels of performance and significant improvement and penalizes poor performance and lack of improvement. The combination of the current Senate provisions could put some hospitals at risk for three separate payment reductions for the same infections/HACs – once through the current policy, once through VBP, and once through the new 1 percent

penalty for hospitals with the highest HAC rates. It is unfair for hospitals to be subjected to triple jeopardy if their performance falls short of their goals.

In addition, the AHA urges Congress to include any collection and public reporting of HACs through the *Hospital Compare* program and display that information alongside other critical quality and safety information. It is important for hospitals and the public to have good, reliable information on infection rates and whether they are improving over time. But we know from past experiences that multiple and conflicting sets of information can paralyze rather than energize improvement activities. Both the House provision requiring HAC reporting through the CDC and the Senate provision to report on information from the current Medicare HAC policy would establish new and conflicting information, with different data sources and methodologies to generate the information. Using the current *Hospital Compare* structure will maintain consistency in collection and reporting and support the inclusion of HACs in VBP.

GRADUATE MEDICAL EDUCATION (GME)

The AHA appreciates that both bills maintain current levels of indirect medical education (IME) payments that are part of Medicare's inpatient prospective payment system. As previously stated, the AHA supports the provision in the House bill that amends the Medicaid statute to explicitly include payments for the cost of GME, both inside and outside the hospital, as legitimate Medicaid payments. Both the House and the Senate reform bills implicitly recognize that expanding coverage to millions of Americans will increase demand for medical care. Likewise, there will be a need for additional physicians, especially in primary care, to meet the needs of newly covered Americans.

The AHA supports the House and Senate provisions to redistribute unused residency positions to hospitals that can fill and use the new positions to expand training in primary care and other needed specialties. We support the need to stimulate physician training, particularly in both underserved urban and rural areas. We also appreciate and support provisions in both bills that ensure these new positions receive full IME and direct GME payments. However, we urge Congress to add new residency positions, not just redistribute unused positions, as part of health care reform legislation. Significant physician shortages are projected for the coming years, and this shortage will only grow worse as newly covered Americans seek services.

The AHA also supports provisions to address resident time spent in non-hospital settings and time spent in non-patient care activities, including didactic conferences and seminars. Today, physician training needs to occur in settings where care is delivered, often outside the traditional inpatient hospital setting.

340B DRUG DISCOUNT PROGRAM

The AHA strongly supports the Senate provision to expand 340B discounts to include inpatient drugs. Both the House and Senate bills expand the 340B drug

discount program, but the Senate bill expands the discounts to cover not only outpatient pharmaceuticals, but also inpatient pharmaceuticals for existing 340B program participants. The Senate bill also would expand 340B eligibility (for both outpatient and inpatient drugs) to certain Rural Referral Centers (RRCs) and Sole Community Hospitals (SCHs) with DSH adjustments at 8 percent or higher, CAHs, freestanding children's hospitals, and freestanding cancer hospitals. The House bill expands eligibility for the 340B program to include RRCs, SCHs, Medicare dependent hospitals (MDHs), CAHs, freestanding children's hospitals, and freestanding cancer hospitals but does not expand 340B discounts to drugs provided during an inpatient stay.

With the high annual cost growth in pharmaceutical prices and the critical role of pharmaceuticals in inpatient care, expanding 340B to cover inpatient drugs is a strong tool in helping hospitals manage costs for their patients. **In addition, while the AHA supports the Senate provisions expanding eligibility to additional hospitals, we prefer the hospital expansion provisions in the House bill that cover more rural hospitals, including MDHs.** The 340B program was designed to help support safety-net hospitals; RRCs, SCHs, MDHs and CAHs all play critical roles in maintaining access to hospital care in rural areas. The 340B program should be expanded to protect and strengthen the safety net in rural areas.

PHYSICIAN SELF-REFERRAL

The AHA strongly supports limitations on self-referrals to physician-owned hospitals and we urge the conferees to use the House bill's trigger date for grandfathering existing physician-owned facilities. The AHA has long supported eliminating the exception for new physician-owned hospitals under the Stark law for self-referrals. Both the House and Senate bills would eliminate this exception. The provisions in both bills would grandfather existing physician-owned hospitals, with requirements for disclosure of financial interests to patients and the public, requirements to ensure bona fide investments and management of conflicts of interest, and limitations on the growth of grandfathered facilities. The House bill grandfathers those facilities certified to participate in Medicare on or before January 1, 2009, while the Senate bill grandfathers those facilities certified by August 1, 2010. An early grandfathering date will ensure that the problems associated with physician self-referrals to hospitals are contained as much as possible.

REDUCING HEALTH DISPARITIES

The AHA supports efforts to reduce health disparities and urges the conferees to focus attention and resources on solutions to disparities, including support to the health care organizations working hard to address the issues and the variety of economic, societal and health delivery factors that contribute to disparities. We are especially concerned about the potential for unintended consequences caused by other provisions in the bills (especially provider payment changes) that could undercut the ability of safety-net hospitals and other providers to care for those that suffer most from health disparities. Both the House and Senate bills include a variety of provisions that

would support efforts to reduce health disparities by addressing health professions education, demonstrations related to successful approaches to reducing health disparities, expanded collection of data about health disparities, cultural competency training for health professionals, and the elevation of minority health issues within HHS.

EXTENSION OF GAINSHARING DEMONSTRATION

The AHA supports the extension of the gainsharing demonstration project established under the *Deficit Reduction Act*, which called for a three-year project. Because there were significant delays in starting the program, both the House and Senate bills would add time to restore a three-year term for the project.

ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS/TAX-EXEMPTION

The AHA does not believe that the new requirements for charitable hospitals and their ability to maintain tax exemption in the Senate bill are necessary, and we urge the conferees to remove these provisions from the final health reform conference report. No similar provisions are included in the House bill.

If the entire section in the Senate bill is not removed, two subsections that are particularly problematic should be removed. Specifically, the AHA supports removal of the requirement that the Department of the Treasury conduct a review every three years of community benefit activities of each exempt hospital. Such a review is unnecessary, expensive for the hospital and would effectively empower the Internal Revenue Service (IRS) to establish requirements for tax exemption based on a flawed reporting mechanism and absent input from communities served by the hospital and those who represent them. In 2010, all tax-exempt hospitals will file a new IRS Schedule H that is seriously flawed. Hospital systems will be particularly disadvantaged because the Schedule does not provide most systems with the opportunity to report the full range of community benefits they provide. The Senate bill also contains a subsection that would require Treasury to issue a report on levels of charity care and trends (e.g., charity care, bad debt and unreimbursed costs for providing services in connection with means-tested and non-means tested government programs, by tax-exempt, taxable and government-owned hospitals). This report is unnecessary and redundant, given other work being performed by the CBO and General Accountability Office (GAO). The report also will be expensive for hospitals and most likely would report inaccurate information. There are serious and pervasive flaws in recent IRS hospital surveys and the Schedule for tax-exempt hospitals to report community benefits. Until the IRS understands and corrects those flaws, a study of this type could not be expected to provide reliable information to policymakers.

MEDICARE EXTENDERS

The AHA supports the House provisions that extend these important expiring programs for two years. The Senate bill provides only a one-year extension**.** The House provisions with two-year extensions include:

- Outpatient hold-harmless payments for certain hospitals in rural areas with 100 or fewer beds and for certain sole-community hospitals with 100 or fewer beds;
- Section 508 wage index reclassifications for the inpatient PPS through September 30, 2011;
- Increasing the work geographic index under the physician fee schedule to 1.0 for localities in which the work geographic index is less than 1.0;
- Grandfathering that allows independent laboratories to continue to directly bill, under the physician fee schedule, for anatomic pathology technical component services provided for certain hospitals' inpatients and outpatients;
- Continuing the existing add-on payment for ground ambulance services – a 3 percent add-on for rural areas and a 2 percent add-on for urban areas – through December 31, 2011;
- The outpatient therapy caps exceptions process;
- Cost-based payment for brachytherapy (not included in the Senate bill); and
- The 5 percent increase in physician payment for certain psychiatric therapeutic procedures furnished in office or other outpatient facility settings or in inpatient hospital, partial hospital or residential care facility settings.

RURAL PROVISIONS

The AHA strongly supports the inclusion of the Senate provisions to help sustain and improve access to care in rural areas in the final conference report. The Senate bill's rural hospitals provisions include:

- Improvements in the payment adjustment for low-volume hospitals: The bill improves the low-volume adjustment for FYs 2011 and 2012 by expanding access to these adjustments by defining a low-volume hospital as one that is more than 15 road miles from another comparable hospital and has up to 1,600 Medicare discharges. The provision also improves the payment amount by requiring the HHS Secretary to use a linear sliding scale ranging from 25 percent for low-volume hospitals with Medicare discharges below a certain threshold, to no adjustment for hospitals with more than 1,600 Medicare discharges.

- A demonstration project on community health integration models: The bill would revise the demonstration project created by the *Medicare Improvements for Patients and Providers Act of 2008* that allows eligible entities to develop and test new models for the delivery of health care services in certain rural counties for the purpose of improving access to, and better integrating delivery of, acute care, extended care, and other essential health care services to Medicare beneficiaries. The bill removes the existing cap on the number of counties that can participate in each state. It also allows physician services to be included within the scope of the demonstration.

- A MedPAC report on Medicare payment adequacy to rural providers: The Senate bill requires MedPAC to report to Congress on Medicare payment adequacy for rural health care providers by January 1, 2011.

- CAH payments: The bill ensures that CAHs are paid 101 percent of costs for all outpatient services they provide, regardless of the billing method elected.

- Rural community hospital demonstration program: The Senate bill extends the Rural Community Hospital Demonstration Program for an additional five years, through December 31, 2010, increases the maximum number of participating hospitals from 15 to 30 and expands the eligible sites to rural areas in 20, rather than 10, states. The *Medicare Prescription Drug, Improvement and Modernization Act of 2003* created this five-year demonstration program to test the feasibility and advisability of reasonable cost reimbursement for rural hospitals with fewer than 51 beds. **The AHA supports allowing hospitals in all states to participate in this demonstration.**

- MDH Program: The bill extends the MDH program for one year, through September 30, 2012. **The AHA urges the conferees to make this valuable program permanent.**

- Medicare Rural Hospital Flexibility Program: The bill extends the Medicare Rural Hospital Flexibility Program through 2012. The *Balanced Budget Act of 1997* established this program, which created CAH designation under Medicare and authorized a grant program that is administered by the Health Resources and Services Administration. **The AHA urges the conferees to make this valuable program permanent.**

- Reasonable cost reimbursement for laboratory services in small rural hospitals: The bill reinstates reasonable cost reimbursement for clinical diagnostic laboratory services for qualifying rural hospitals with fewer than 50 beds for one year, from July 1, 2010 through July 1, 2011.

EQUITABLE TREATMENT FOR RURAL SAFETY-NET PROVIDERS

The AHA encourages the conferees to expand several Senate-proposed programs that support Federally Qualified Health Centers (FQHCs) to other similar rural safety-net providers such as Rural Health Clinics, FQHC-Look-Alike clinics and Indian Health Services and Tribal Health Clinics. The Senate bill includes several special programs that provide additional support to FQHCs, including implementation of a prospective payment system for ambulatory care providers, demonstration grants for Family Nurse Practitioner Training Programs, establishment of community-based collaborative care networks, establishment of an Early Detection of Certain Medical Conditions Related to Environmental Health Hazards, and creation of a payment floor. Rural health clinics, FQHC-Look-Alike clinics, and Indian health clinics also should be eligible for these programs.

WAGE INDEX

The AHA urges the conferees to retain the Senate wage index provisions in the final health reform conference report. The Senate bill contains two hospital wage index provisions that are critical for certain hospitals in order to receive adequate payments for Medicare inpatient services. First, the bill includes a provision to require the HHS Secretary to use, until FY 2014, the area wage index reclassification thresholds of the average hourly wage that were in effect prior to FY 2009. Second, the bill includes a provision that would require the Secretary to apply the wage index rural floor budget-neutrality adjustment on a national basis for FY 2011 and beyond.

PAYMENT EQUITY FOR HOSPITALS IN PUERTO RICO AND U.S. TERRITORIES

The AHA urges the conferees to include in the final conference report the House provision to increase the payment cap for Puerto Rico and all the territories from 2011 to 2019 within the $10.35 billion allotment. Beginning in 2020, the provision would bring Puerto Rico and the territories to full FMAP parity with the states.

In addition, the AHA urges the conferees to raise Medicare inpatient payments to Puerto Rico and territory hospitals to the level of hospitals in the 50 states. Medicare payments to Puerto Rico hospitals are below parity with Medicare payments to hospitals in the 50 states. For example, Medicare inpatient payments to Puerto Rico hospitals equal the sum of 25 percent of a Puerto Rico-specific rate and 75 percent of the federal national rate, yet residents of Puerto Rico pay the same Social Security and Medicare taxes as other U.S. residents. In addition, Puerto Rico hospitals are disadvantaged under the Medicare DSH formula. This formula takes into account Medicare Supplemental Security Income (SSI) patient days, but there is no SSI program in Puerto Rico.

LONG-TERM CARE HOSPITALS (LTCHS)

The AHA supports provisions in the Senate bill that extend for two years selected LTCH provisions in the *Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA)*. These provisions would further delay full implementation of the 25 percent rule, the short-stay outlier cut, and the one-time budget-neutrality adjustment planned by CMS. The current moratorium on new LTCH beds and facilities, with exceptions, also would be extended. This extension is important so that MMSEA-required studies can be completed and new criteria for LTCHs can be developed.

STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS (MDHS)

The AHA supports language in the Senate bill to require the HHS Secretary to conduct a study on the need for an additional payment for urban MDHs for inpatient services. The legislation defines an urban MDH as one that does not receive IME or DSH payments; is not a CAH, RRC, SCH or small rural MDH; and for which more than 60 percent of its inpatient days or discharges for two of the last three cost-reporting periods were attributable to Medicare beneficiaries enrolled in Part A. Understanding these hospitals is critical to ensure that all urban hospitals, and especially those treating significant numbers of Medicare patients, receive adequate Medicare payment.

TREATMENT OF CERTAIN COMPLEX LABORATORY TESTS

The AHA urges the conferees to allow hospitals to participate in the Senate bill's proposed laboratory demonstration program and receive separate payments for certain complex laboratory tests. The Senate bill includes a provision that negatively affects hospital-based laboratories compared to independent laboratories. The bill establishes a two-year demonstration project under which the HHS Secretary would pay laboratories separately for certain complex diagnostic laboratory tests (i.e., "unbundle") that are conducted using specimens obtained from individuals while they are hospital inpatients, and for which payment would otherwise be bundled into the hospital inpatient payments. If this provision remains in the bill, participation in the demonstration project should be extended to hospital-based laboratories so that they can also receive separate payments for certain complex tests.

PAYMENT REDUCTIONS FOR CLINICAL LABORATORY TESTS

The AHA urges the conferees to reject the Senate bill's 1.75 percentage point reduction in Medicare laboratory payments and adopt a more equitable approach to raise $750 million in revenue each year by replacing the update reduction with the original Senate bill's proposal to apply a fixed annual fee on all clinical laboratories based on overall market share. Both the Senate and House bills seek to raise additional revenue or reduce costs through provisions that affect clinical laboratories. The Senate bill includes a new Medicare laboratory payment reduction of 1.75 percentage points in FY 2011 through FY 2015, in addition to provisions in both the Senate and House bills that would reduce the laboratory payment updates using a productivity adjustment. The provision to reduce payments by 1.75 percentage point was

included in the Senate manager's amendment and replaced a previous provision in the chairman's mark that would have collected an annual aggregate fee of $750 million from all clinical laboratories. The $750 million fee on laboratories would have been applied annually to individual clinical laboratory providers based on each laboratory's overall market share. This approach would distribute more fairly the impact of this revenue-raising provision. However, the additional 1.75 percentage point reduction to Medicare laboratory payments will have a disproportionately negative effect on hospital-based laboratories that provide a much higher proportion of Medicare services.

MEDICAL DEVICE TAX

The AHA urges the conferees to adopt the Senate approach on medical device "taxes" or fees. The AHA believes that the Senate provision will make it more difficult for device manufacturers to easily pass the "fee" on to hospitals and better ensure that device manufacturers contribute to the nation's goal of expanding coverage to more Americans. We also support the House provision effective date of 2013. Both the Senate and House device tax provisions would raise approximately $20 billion in new federal revenue over the ten-year period. The Senate reform bill would charge an annual fee to medical device companies, beginning with $2 billion per year in FY 2011 and increasing to $3 billion per year in FY 2018. The fee would be assessed across device manufacturers based on their market share.

The AHA is concerned that, under the House proposal, device manufacturers will try to shift this new fee to customers, hospitals and other purchasers of medical devices. The House reform bill establishes a 2.5 percent excise tax on medical devices sold for use in the U.S. The tax applies to the "first sale" of all devices (type I, II, and III) sold in the U.S. Device sales for resale, after production, manufacture, or importation are not considered "first sale" and would not be subject to the tax. Hospital charges for devices that are used for patients are not considered "resale" or "retail" for purposes of the device tax. While the House proposal does not impose a "sales" tax, it is a tax on each individual device and it is likely that manufacturers will add-on the 2.5 percent tax at the time of sale. When a hospital purchases directly from the manufacturer, the hospital would likely be charged the 2.5 percent tax.

WORKFORCE COMMISSION

The AHA supports provisions in the House and Senate reform bills that create a workforce commission to develop and coordinate national workforce priorities, goals and policies. As the largest employer group of health care professionals, the AHA urges the conferees to include explicitly a hospital representative to serve on the workforce commission. Additionally, given the training and educational needs of the future health care workforce, at least one representative on the commission should have specific expertise in GME payment and policies.

EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE

The AHA urges the conferees to include, but modify, a Senate provision that allows the Secretary to change the coverage status of *existing* preventive services if the U.S. Preventive Services Task Force (USPSTF) recommends against covering the preventive service. We recommend that the conferees add a requirement that CMS issue a proposed rule allowing public comment before modifying or denying coverage of a preventive service, even those rated "D" (or "recommends against") by the USPSTF. Currently, the bill does not require a notice and comment period.

COMPARATIVE EFFECTIVENESS RESEARCH

The AHA strongly supports efforts to advance clinical effectiveness research as proposed in both the Senate and House health reform bills. The AHA urges the conferees to allow comparative effectiveness research to evaluate both the clinical and cost effectiveness of treatment. The Senate bill currently calls for a research institute to conduct comparative *clinical* effectiveness research. We feel that the research must not be limited to clinical effectiveness, but also should include the cost effectiveness of the treatment.

REPEAL OF THE "45 PERCENT MEDICARE TRIGGER"

The AHA supports the House proposal to repeal the 45 percent trigger provision in the final health reform conference report. Current law requires the annual Medicare Trustees' report to include an estimate of the year in which general revenues will account for more than 45 percent of Medicare funding. If two consecutive trustees' reports project that this portion will exceed 45 percent within the next six years, then the President must submit legislation to reduce the portion to less than 45 percent. The House bill would eliminate this requirement.

MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL

The AHA supports provisions in the Senate and House bills that require the HHS Secretary to establish a process for voluntary disclosure of potential violations of the physician self-referral law. We urge the conferees to use the language in the House bill because it suspends the deadline for returning an overpayment and provides flexibility for the Secretary to determine amounts for repayment based on the nature and/or extent of the violation. Without modification, the Senate provision could require a hospital to repay an exorbitant amount, which is what the protocol is partially designed to prevent.

The House bill requires the HHS Secretary to create a protocol for providers to disclose an actual or potential violation of the self-referral law. It also grants the Secretary authority to determine the amount to be repaid. Currently, any payment for a service provided in violation of the self-referral law is subject to repayment without regard to the nature or extent of the violation. The bill also suspends the time frame for returning overpayments for matters disclosed through the protocol until the Secretary determines the amount of an overpayment that must be repaid. The Senate bill does not suspend the

time frame for returning an overpayment for matters pending review by the Secretary under the Disclosure Protocol. The Senate version will deny hospitals the intended benefit of the protocol and could require repayment of a greater amount than the government should recover.

ANTIKICKBACK LAW

The AHA urges the conferees to reject a provision in the Senate bill that explicitly allows antikickback violations to also be subject to potential penalties under the False Claims Act (FCA). The Senate bill amends the antikickback law to subject virtually all violations to penalties under the FCA. We believe the change will involve hospitals in unnecessary and unintended litigation. The stated purpose of the provision is to address a problem experienced by the Department of Justice (DOJ) in kickback prosecutions against device companies and physicians. While the bill identifies hospitals as innocent third parties in such schemes, hospitals could be swept into litigation as an unintended consequence. Congress recently addressed this problem by amending the FCA itself in the *Fraud Enforcement and Recovery Act of 2009* (FERA). If the provision is not omitted, the AHA encourages removing the ambiguous language that will result in unwarranted FCA litigation for hospitals and unnecessary litigation costs.

KEY FRAUD/ABUSE PROVISIONS

RECOVERY AUDIT CONTRACTORS (RACS)

The AHA urges the conferees to remove the Medicaid RAC provision from the final health reform conference report. We believe that a new Medicaid RAC program would be additive to existing Medicaid audit efforts and unnecessary for maintaining or improving program integrity. The Senate bill would extend RACs to Medicare Parts C and D and to the Medicaid program. State Medicaid agencies already have the authority to implement RACs for their Medicaid programs and two-thirds have done so. In addition, CMS is implementing the *national* Medicaid Integrity Program to audit the accuracy of state Medicaid programs.

FALSE CLAIMS ACT AMENDMENT

The AHA urges the conferees to reject the Senate bill's FCA amendment that would enable individuals with no personal knowledge of the transactions to claim to be whistleblowers exposing a fraud – even if those transactions were already publicly exposed to a government entity. The Senate bill introduces a new amendment to the FCA that would substantially narrow a defense to opportunistic, parasitic whistleblower lawsuits. Current law already strikes an appropriate balance between the interests of the government, the whistleblower and the defendant. This amendment would allow individuals to pose as whistleblowers when they have no personal knowledge of allegedly false claims.

This provision would repeal the existing "public disclosure" provision, which bars whistleblower lawsuits based on publicly disclosed allegations unless the whistleblower has "direct and independent knowledge" of the fraud and reports it to the government before the disclosure is made. The provision will significantly increase the number of lawsuits brought and maintained by opportunistic plaintiffs by shortening the list of public disclosures that trigger the bar for whistleblower action, and enable individuals with no personal knowledge of the transactions to claim to be whistleblowers exposing a fraud (even if those transactions were already exposed to a state Medicaid agency and CMS).

NEW CIVIL MONETARY PENALTIES (CMPS) FOR FALSE STATEMENTS ON PROVIDER ENROLLMENT APPLICATIONS

The AHA urges the conferees to reject the "damages" provision of the Senate's proposed administrative remedies for false statements made in Medicare provider enrollment applications, contract bids and other Medicare or Medicaid documents. The Senate bill introduces new administrative remedies for material false statements made in Medicare and Medicaid documents. In addition to exclusion and a civil penalty of $50,000 per statement, the Senate bill would allow the Office of the Inspector General (OIG) to collect "damages" of "3 times the total amount *claimed*" from Medicare and Medicaid, regardless of whether payment was actually made or costs were incurred for the successful delivery of medically necessary and appropriate services to patients. This provision could result in draconian refund obligations requiring providers to refund three times the amount paid to them for medically necessary and appropriate services. Egregiously false and fraudulent statements in applications already are punishable under a number of criminal statutes. Penalties like exclusion and/or a $50,000 per-statement penalty may be appropriate in less egregious circumstances; declaring legitimate services to have had no value and threatening a non-criminal provider with financial ruin in an administrative proceeding would not be appropriate.

CONCLUSION

Good health all of one's life and the availability of health care that is safe, reliable, affordable, and as good as it can be when it is needed is a universal aspiration that cuts across all American economic, political, ideological, race, age and gender demographics. As hospitals, our goal is to ensure universal coverage for health care services, and we have sought the realization of that goal through *Health for Life*, our multi-year health care reform initiative. Like you, we believe that goal is achievable, and that health care reform will move the nation closer to that goal. The AHA and its members look forward to the passage of meaningful health care reform that covers nearly all Americans, provides a pathway to delivery system reform, and ensures that American health care remains the best in the world.

If you have any question about our comments, please contact Linda Fishman, Senior Vice President, Public Policy Analysis & Development, at (202) 626-4628 or lfishman@aha.org. We look forward to working with you as you undertake deliberations on these important fundamental issues.

Sincerely,

Rick Pollack
Executive Vice President