American Hospital Association

Protecting and Improving Care for Patients and Communities

Medicare

Issue

Americans depend on hospitals to be there in times of need – to respond swiftly to emergencies, welcome new life into the world, help patients cope with acute and chronic illnesses, and care for those who have no place left to turn – 24 hours a day, 365 days a year. But increasing financial pressures are severely challenging hospitals' ability to fulfill this expectation. In 2004, a staggering 68 percent of hospitals – roughly 3,300 hospitals – were paid less than the cost of caring for Medicare patients. That's more than 463 hospitals than in 2003. Medicare margins have dropped to a 12-year low, and the Medicare Payment Advisory Commission predicts that overall Medicare margins will remain negative in 2007.

Contributing to Medicare payment challenges is a host of significant pressures – largely beyond hospitals' control. A sustained workforce shortage and rising health care liability premiums continue to drive costs higher. In addition, access to capital is challenging as the average age of hospital facilities and the demand for expensive new information systems continues to climb.

AHA View

The Federal Budget. The administration has proposed almost $36 billion in cuts to Medicare in its fiscal year (FY) 2007 budget proposal – cuts that could adversely impact patients and caregivers. However, Capitol Hill appears disinclined to support the administration's proposal. The Senate's FY 2007 budget resolution spares hospitals from Medicare cuts, and the House Budget Committee passed a resolution that also exempts Medicare from spending cuts. However, the resolution includes $4 billion in savings over five years in entitlement spending, which may put Medicare at risk for cuts.

The administration's budget also proposes to reduce the inpatient hospital update by 0.45 percentage points in FY 2007, 0.4 in 2008 and 0.4 in 2009. The majority of hospitals do not receive adequate Medicare reimbursement, and Medicare underfunding to hospitals has grown drastically in recent years – to losses of more than $15 billion in 2004. A full update is needed if America's hospitals are to keep up with inflation and fulfill our roles of caring for patients, preserving the safety net, being ready for unexpected emergencies and disasters, and modernizing the health care system. **The AHA will continue to oppose payment reductions and push for Medicare payment improvements to hospitals.**

Medicare Bad Debt. Nearly 90 percent of Medicare beneficiaries have some type of supplemental insurance coverage to help pay for Medicare's deductibles and copayments. For seniors without supplemental coverage – many of whom are on fixed incomes – contributing their share of the total Medicare payment can be difficult, and many are unable to pay. These uncollected amounts, or Medicare bad debts, total more than $2 billion a year for hospitals.

Prior to the Balanced Budget Act of 1997 (BBA), Medicare reimbursed hospitals 100 percent of Medicare-related bad debt, but the BBA reduced Medicare reimbursement for bad debt to 55 percent of cost. Congress increased bad debt reimbursement to 70 percent in the Benefits Improvement and Protection Act of 2000. Now the administration is proposing to completely eliminate reimbursement for Medicare bad debt over four years – a move that would cut payments to all hospitals, including critical access hospitals (CAHs), by more than $6.2 billion over the next five years.

Eliminating Medicare bad debt reimbursements to hospitals sends the wrong message to America's seniors and could limit access to hospital services.

In the Deficit Reduction Act of 2005 (DRA) Congress froze physician Medicare payments for one year to avoid a scheduled 4.4 percent cut in their Medicare payment update. A further cut is

scheduled for 2007 for physician payments. The AHA supports fair and adequate payment rates for physicians, and supports eliminating any physician cuts. However, other provider payments, including hospital payments, should not be reduced to eliminate the scheduled physician cut.

Inpatient PPS. The Centers for Medicare & Medicaid Services' (CMS) recently released proposed rule for the FY 2007 Medicare inpatient prospective payment system (PPS) includes the most significant changes since the program began in 1983. CMS is proposing major changes in the calculation of diagnostic-related groups (DRG) relative weights by using hospital-specific relative values and a modified version of costs instead of charges. CMS also discusses refinements to the DRGs to account for patient acuity, with implementation likely in FY 2008. These changes create a significant level of re-distribution between DRGs and among hospitals. The rule also proposes a 3.4 percent market basket update and many other provisions including reporting of hospital quality measures, wage index and reclassifications, graduate medical education payments, sole community hospital status, outliers and more. The AHA is analyzing the rule to understand its impact. We will work with the hospital field to develop our position and best response to the regulation.

Inpatient Rehabilitation 75% Rule. The 75% Rule is one of the criteria an inpatient rehabilitation facility (IRF) must satisfy to be eligible for Medicare reimbursement. Under the rule, when fully phased in, 75 percent of patients discharged during a cost report period must be treated for one of 13 conditions. CMS changed the list of eligible conditions in July 2004 from 10 to 13 conditions, which fell far short of modernizing the 20-year old rule. The phase-in of the 75% Rule continues to place great stress on IRFs. Currently, the threshold is set at 60 percent, where it will remain through June 2007 due to the one-year extension recently authorized by the DRA. Approximately 40,000 fewer Medicare beneficiaries were treated in rehab facilities during the first year of the phase-in and it is projected that an additional 64,000 patients would not be treated in rehab facilities during the second year of the phase-in. These reductions – more than 100,000 during the first two years – far exceeds CMS' projection that just 7,000 patients would be turned away by the revamped 75% Rule. Clearly, CMS has gone too far.

In 2005, the Government Accountability Office and the National Institutes of Health called for more research on the appropriate treatments and settings for post-acute rehabilitation patients. The AHA and other national groups are developing a research plan to complement current studies and provide a roadmap for the IRF field. Holding the 75% Rule at the current level while this research is pursued is extremely important. In addition, the administration has proposed to freeze the IRF payment update for FY 2007 and to reduce the FY 2008 and 2009 market basket updates by 0.4 percentage points, which would cut payments by $1.6 billion over five years.

The administration's budget also would reduce IRF payments for joint replacement patients by $2.4 billion over the next five years. These arbitrary and excessive cuts would heighten the current volatility within the IRF field and further threaten access to care. Given the magnitude of reduced IRF access due to the 75% Rule, it is inappropriate to further penalize joint replacement patients through a severe payment cut.

Congress should hold rehab qualification criteria at the 60 percent level while more research is conducted to provide a scientific basis for targeting patients who need inpatient medical rehabilitation. In addition, payment reductions to IRFs are inappropriate in this time of great volatility.

Long-Term Care Hospitals. CMS' proposed rule for long-term care hospitals (LTCHs) recommends several significant changes that are of concern to the AHA – most notably the

proposal to omit the 3.6 percent market basket update and to change the short-stay outlier policy. The alarming net impact of CMS' proposal – a 14.7 percent cut in Medicare payments – is excessive and would severely and inappropriately threaten patient access to LTCH care. LTCHs provide intense care to patients who require much longer lengths of stay than a typical patient in an inpatient hospital, such as those on ventilators and burn victims. LTCHs have an average length of stay of 25 days or greater. Recent LTCH growth is being watched closely by Congress, CMS and others. Any proposed efforts regarding LTCHs should be based on balanced and thoughtful policymaking that ensures access for patients for whom LTCH care is medically appropriate.

A highly anticipated report from Research Triangle Institute International will provide guidance on how to expand the current LTCH criteria to help accomplish the goal of targeting LTCH care to the right patients. Unfortunately, CMS is not waiting for its contractor's recommendations before instituting reform in LTCH care. Instead, the agency is proposing to limit LTCH care using ineffective proxies such as referral source and length of stay. CMS should allow the pending report to be completed and use it as a guide for developing enhanced LTCH criteria to target care to patients needing an acute level of care in a LTCH. No major policy changes should be implemented until this report is evaluated, and a proposal on how to enhance the current criteria is developed and implemented. CMS should rescind its current proposal.

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

The AHA continues to advocate for legislation that will address the needs of small rural hospitals, including:

- **The Rural Community Hospital Assistance Act** (S. 933/H.R.2350) would expand cost-based reimbursement to hospitals with between 25 and 51 beds eligible for Medicare inpatient and outpatient services, and provide cost-based reimbursement for CAH skilled nursing facilities, home health services and ambulance services. The bill was introduced by Sens. Sam Brownback (R-KS) and Ben Nelson (D-NE) and Reps. Jerry Moran (R-KS) and Rubén Hinojosa (D-TX).

- **The Sole Community Hospital Preservation Act** (H.R.2961) would make permanent the hold harmless provision for outpatient payments to sole community hospitals and improve inpatient payments to sole community hospitals. The bill was introduced by Reps. Greg Walden (R-OR) and John Tanner (D-TN).

- **The Medicare Rural Home Health Payment Fairness Act** (S.300/H.R.11) would provide for a two-year extension of the temporary 5 percent Medicare payment increase for home health services furnished in rural areas. The legislation is sponsored by Sen. Susan Collins (R-ME) and Rep. Greg Walden (R-OR).

- **Pulmonary and Cardiac Rehabilitation Act** (S.1440) would establish a statutory benefit category under Medicare for pulmonary and cardiac rehabilitation services. The bill was introduced by Sens. Mike Crapo (R-ID) and Blanche Lincoln (D-AR).

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Critical Access Hospitals. The CAH program is essential for maintaining adequate access to health care services in rural communities. However, the survival of these isolated health care facilities could be threatened without needed improvements to the CAH program. The AHA supports the following legislative solutions:

- **The Rural Health Equity Act** (H.R.880) would ensure that Medicare Advantage plans pay CAHs at least 101 percent of costs for inpatient and outpatient services, regardless of whether the CAH has a contract with the patient's Medicare Advantage plan. The bill was introduced by Reps. Ron Kind (D-WI) and Tom Osborne (R-NE).

- **The Critical Access to Clinical Lab Services Act** (S.236/H.R.1016) would reinstate cost-based reimbursement to CAHs for lab services provided to patients who are not physically present in the hospital. The legislation was introduced by Sens. Ben Nelson (D-NE) and Susan Collins (R-ME), and Reps. Butch Otter (R-ID) and James Oberstar (D-MN).

- **The Safety Net Inpatient Drug Affordability Act** (S.1840/H.R.3547) would expand the 340b drug discount program to include inpatient services and allow CAHs to participate. The 340b drug discount program provides safety net hospitals with the ability to purchase pharmaceuticals at significantly reduced rates. Currently, CAHs are unable to participate because they do not receive Medicare disproportionate share payments. The legislation was introduced by Sens. John Thune (R-SD) and Jeff Bingaman (D-NM), and Reps. JoAnn Emerson (R-MO) and Bobby Rush (D-IL).

On the regulatory front, CMS' State Operations Manual's Interpretive Guidelines relating to CAHs are an example of regulatory overreach. CMS has restricted the use and location of observation beds in CAHs and the circumstances in which a CAH can relocate and maintain its critical access status. Specifically, the guidelines alter the definitions of mountainous terrain and secondary roads, and require review after one year as to whether the relocated hospital continues to serve 75 percent of the same population, provide 75 percent of the same services and employ 75 percent of the same staff. Necessary providers that fail the 75 percent test would lose their CAH status and be forced to convert back to the inpatient PPS, hurting these facilities' ability to continue providing care in their communities. **We will push CMS to change the interpretive guidelines, so that observation beds are not counted toward the total CAH bed count. We also will urge CMS to adopt a five-mile safe harbor for relocating CAHs before applying the 75 percent test.**

Outpatient PPS. As hospital care continues to shift to the outpatient setting, we must address problems created by the outpatient PPS. While the numerous coding and data problems associated with the outpatient system have improved somewhat, the fundamental problem still exists: Medicare pays only 87 cents for every dollar of outpatient care costs. The outpatient reform provisions of the MMA, which alter the payment methodology for outpatient drugs, will mean that payment rates will continue to fluctuate between the various ambulatory payment classifications – the category of payment for outpatient services –with an ongoing lack of predictability or stability for providers. Further, while the Deficit Reduction Act of 2005 provided some relief for some small rural hospitals by extending the hold-harmless provision through 2008, full relief is needed for all hospitals.

The AHA supports legislation to create a pool of new resources to address the most underfunded outpatient hospital services by enhancing payments for clinic and emergency room visits. In addition, we support making rural hold-harmless payments permanent to ensure that small rural hospitals and sole community hospitals are financially sheltered from outpatient PPS losses.