

Medicare

Background

America's hospitals have a long tradition of providing care for all who seek it. But that mission is threatened by an underfunded Medicare program. Recently, the Medicare Payment Advisory Commission (MedPAC) reported that Medicare payments continue to fall well below the cost of caring for America's seniors. MedPAC estimates that aggregate Medicare hospital margins in fiscal year (FY) 2012 will be negative 7.0 percent.

At the same time, hospitals face enormous changes associated with the *Patient Protection and Affordable Care Act of 2010 (ACA)*, as well as challenges and cost pressures related to growing uncompensated care, labor shortages, the adoption of electronic health records and the administrative burden of responding to requests from myriad Medicare contractors. Hospitals need adequate Medicare payment to ensure that patients and communities receive the care they expect and need.

AHA View

The AHA's 2012 advocacy agenda focuses on ensuring hospitals have the resources they need to provide high-quality care and meet the needs of their communities. For hospitals participating in Medicare, we are:

- Advocating for adequate Medicare payments that cover the costs of treating America's seniors;
- Encouraging Congress to shore up payments for hospitals that train the physicians of the future;
- Working to extend expiring Medicare provisions; and
- Improving Medicare payments to rural hospitals.

Budget Cuts. In February, President Obama released a budget outline for FY 2013. The outline, which is similar to a proposal the White House released in September, calls for cutting Medicare by about \$268 billion and Medicaid by \$52 billion over 10 years. House Budget Chairman Paul Ryan's budget, which the House passed in April, also includes many Medicare program cuts. These budget proposals, as well as other deficit and spending reduction bills, will put hospitals at risk of Medicare cuts in several areas. The most concerning include:

- *Bad debt.* The administration proposes to reduce bad debt payments to 25 percent for all eligible providers, including hospitals, over three years starting in FY 2013, saving approximately \$36 billion over 10 years from all providers; (a reduction of bad debt payments to 65 percent for all providers was signed into law as part of the *Middle Class Tax Relief and Job Creation Act of 2012*).
- *Indirect Medical Education (IME).* The administration proposes to reduce the IME adjustment by 10 percent beginning in 2014, saving approximately \$10 billion over 10 years;

- *Rural hospitals.* The administration proposes changes to payments for rural providers. Starting in FY 2013, it would reduce critical access hospital (CAH) payments from 101 percent to 100 percent of reasonable costs. In addition, effective in FY 2014, it would eliminate the CAH designation for hospitals that are less than 10 miles from the nearest hospital. Together, the administration estimates these rural proposals would save approximately \$2 billion over 10 years.
- *Post-acute care.* The administration proposes several across-the-board post-acute update cuts, along with lowering inpatient rehabilitation facilities' (IRF) reimbursement for selected patients to the skilled nursing facility level payment, and raising the current IRF 60% Rule threshold to 75 percent. Altogether, the administration estimates these changes would save \$63 billion over 10 years.
- *Independent Payment Advisory Board (IPAB).* The administration proposed to strengthen IPAB by reducing its growth rate target from GDP per capita plus 1 percent to GDP plus 0.5 percent and providing additional enforcement tools.

Given the economic pressures faced by hospitals, which serve as the nation's health care safety net – and given that Medicare already pays hospitals less than the cost of providing services – the AHA is very concerned about cuts that affect the work hospitals do for their communities. **The AHA will continue to work with the administration and Congress to avoid detrimental cuts while strengthening health care in America.**

Inpatient PPS Rule. The AHA anticipates that in the FY 2013 inpatient prospective payment system (PPS) proposed rule the Centers for Medicare & Medicaid Services (CMS) will continue to address alleged payment increases related to implementing the Medicare-severity diagnosis-related group (MS-DRG) system. Specifically, CMS believes that adoption of the MS-DRGs led to coding and classification changes that increased aggregate hospital payments without a corresponding increase in actual patient severity of illness.

The AHA expects that in the FY 2013 inpatient PPS rule CMS will propose a final permanent documentation and coding cut of 1.9 percent. The agency also will likely propose to reverse out last year's 2.9 percent cut that was made to recoup the remainder of the alleged payment increases from FYs 2008 and 2009. Thus, the net impact of these two proposals is expected to result in a 1.0 percent payment increase in FY 2013. **Nevertheless, the AHA continues to assert that CMS has used a flawed methodology and is overstating the effect of the documentation and coding change.**

The AHA also expects CMS to propose how it intends to manage payments under the hospital inpatient value-based purchasing (VBP) and the readmissions reductions programs, both slated to begin in FY 2013. The AHA will continue to work to ensure that the VBP program complies with the law and rewards providers that demonstrate excellence and improvement in patient safety and effective care.

Last year's inpatient PPS rule finalized three readmissions measures that CMS will use in the readmissions reduction program. Although the statute directs CMS to exclude readmissions that are unrelated to the prior discharge, such as planned readmissions and transfers, the agency chose instead to exclude only a very limited set of planned readmissions. **This small set of existing exclusions does not meet the statutory requirement that unrelated readmissions be excluded from the measures. Accordingly, the AHA strongly disagrees with CMS's policy and believes the agency has ignored Congress' intent that the measures be modified to explicitly exclude unrelated and planned readmissions. We will work with the administration and Congress to ensure that CMS implements this program appropriately.**

Wage Index. The area wage index is greatly flawed in many respects. It is highly volatile from year-to-year, is self-perpetuating (in that hospitals with low wage indexes are unable to increase wages to become competitive in the labor market) and uses geographic boundaries that create "cliffs" when nearby hospitals have very different wage index values. These fundamental problems warrant a full and comprehensive re-evaluation and redesign of a system that CMS itself acknowledges is burdensome and of questionable integrity.

There is a great deal of activity around the hospital wage index. In April 2011, CMS issued a report by its contractor, Acumen, on an alternative wage index methodology and solicited public comments. In June 2011, the Institute of Medicine (IOM) issued a report containing recommendations for CMS on the wage index and the geographic practice cost index. The IOM's report took an entirely different approach and consequently had recommendations that departed significantly from those made in the Acumen report. Also, the IOM announced that it will issue a follow-up report this June. In addition, the ACA required that CMS provide a plan to Congress to comprehensively reform the Medicare hospital wage index. CMS released its report in mid-April 2012 in which the agency proposed that Congress implement a hospital commuting based wage index.

In recognition of the substantial challenges entailed in revising such an imperfect wage index, in July 2011, the AHA Board of Trustees created a Wage Index Task Force to further examine the issue and analyze reports that the IOM and CMS are required to complete. The task force has met several times and continues its deliberations to develop recommendations and principals for reform by fall 2012.

Self Referral to Physician-owned Hospitals. The ACA placed restrictions on physician self-referral to hospitals in which they have an ownership interest and limited expansion of those existing specialty hospitals that were grandfathered in the law. The AHA strongly supports these restrictions and successfully pushed for their inclusion in the ACA. However, many physician-owned hospitals have pushed for repeal of these important restrictions. Since enactment, there have been several attempts to legislatively repeal or water down the ACA by repealing new limits on physician referral to hospitals in which they have an ownership interest or eliminating the requirement that physicians disclose their ownership interest in hospitals to patients. These proposals were unsuccessful. **The AHA opposes any legislation to repeal or water down the ACA provisions and urges Congress to maintain the restrictions on physician self-referral that were included in the law.**

Direct Supervision of Hospital Outpatient Therapeutic Services. In calendar years (CYs) 2009-2012 outpatient prospective payment system (OPPS) rules, CMS mandated new requirements for “direct supervision” of outpatient therapeutic services. For 2012, CMS made changes to its policy, several of which are consistent with AHA recommendations.

Extension of Enforcement Delay. As the AHA requested, CMS extended for an additional year – through CY 2012 – its decision not to enforce the direct supervision policy for therapeutic services provided in CAHs and in rural hospitals with 100 or fewer beds (those eligible for OPPS hold harmless payments). CMS states that this extension is intended to allow these hospitals time to meet the required supervision standard while the agency completes its review of supervision levels for some services.

Process for Independent Review of Alternate Supervision Levels. In its CY 2012 OPPS final rule, the agency established an independent review process that will allow for an assessment of the appropriate supervision levels for individual hospital outpatient therapeutic services. CMS designated the Advisory Panel on Hospital Outpatient Payments (HOP Panel), formerly known as the “Advisory Panel on APC Groups,” as the independent review body that will advise the agency. CMS also added four new hospital representatives as voting members to weigh in on supervision issues, two from CAHs and two from other small rural PPS hospitals. While the AHA appreciates additional rural hospital representation on the advisory panel, we are disappointed that CMS did not accept our recommendation to guarantee an equal voice for rural concerns by adding a total of eight rural hospital representatives.

CMS charged the HOP Panel with recommending a supervision level – general, direct or personal – to ensure an appropriate level of quality and safety for

delivery of a given service. After considering the panel's recommendations, CMS will use a sub-regulatory process in which its preliminary decisions will be posted on the OPPTS website for a 30-day period of informal public input. After consideration of public comments, CMS will issue its final decisions, which will be effective either in July or January following the most recent HOP Panel meeting.

Non-physician Practitioners May Provide General and Personal Supervision.

Because the HOP Panel is authorized to recommend that CMS assign either personal or general supervision to services, CMS explicitly provides that non-physician practitioners (NPP) who are authorized to furnish direct supervision also may furnish general or personal supervision for certain services, as required by CMS.

While the AHA appreciates CMS's efforts to make the requirements more flexible, we continue to be concerned that, faced with shortages of health care professionals, particularly in rural areas, hospitals and CAHs will have difficulty implementing these requirements, and timely access to services will be reduced. CMS's decision to extend and expand its enforcement delay is helpful for CAHs and small rural hospitals. However, those hospitals not included under the enforcement delay remain subject to enforcement action around the onerous policy. We continue to disagree with CMS's repeated assertion that it has required direct supervision of outpatient therapeutic services since 2001.

The AHA continues to work with CMS and Congress to make more fundamental changes to the OPPTS supervision policy. A workable solution would:

- Adopt a default standard of "general supervision" for outpatient therapeutic services;
- Establish a reasonable exceptions process – including an independent review panel and public rulemaking process – to identify specific procedures that should be subject to the two-tiered or direct supervision levels;
- Ensure that for CAHs the definition of "direct supervision" is consistent with the CAH conditions of participation that allow a physician or NPP to present within 30 minutes of being called; and
- Prohibit enforcement of CMS's retroactive reinterpretation that the "direct supervision" requirements applied to services furnished since January 1, 2001.

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

Last September, the President’s Plan for Economic Growth and Deficit Reduction called for reducing the indirect medical education (IME) adjustment by 10 percent, from 5.5 percent to 5.0 percent, which would cut Medicare medical education payments by approximately \$9 billion over 10 years. Other policymakers – such as the Simpson-Bowles deficit commission – have recommended reducing the IME adjustment by 60 percent and limiting hospitals’ direct graduate medical education payment to 120 percent of the national average salary paid to residents in 2010, which would reduce Medicare medical education payments by an estimated \$60 billion through 2020.

With the help of strong advocacy from the field, Congress has not reduced Medicare direct or indirect medical education payments to teaching hospitals. **The AHA will continue to oppose reductions in Medicare funding for IME and direct graduate medical education and also advocate for maintaining existing funding for graduate medical education conducted in children’s hospitals.** (Refer to “Annual Appropriations” issue paper.)

Rural Hospitals. Because of their small size, modest assets and financial reserves, and higher share of Medicare patients, rural hospitals disproportionately rely on government payments. While their Medicare margins have improved in recent years, more than 59 percent still lose money treating Medicare patients. **The AHA is pleased that Congress provided relief on certain issues as part of the *Middle Class Tax Relief and Job Creation Act of 2012*. However, this bill did not go far enough in extending certain policies critical to rural hospitals. In 2012, we continue to work with Congress to provide small, rural hospitals with adequate reimbursement, including extension of expiring rural provisions.** For more information, see the AHA’s issue paper “Rural or Small Hospitals.”

POST-ACUTE CARE

Long-Term Care Hospitals (LTCH). The AHA continues to support elimination of CMS’s 25% Rule and we continue to push for implementation of patient and facility criteria for LTCHs. The AHA-supported *Long-Term Care Hospital Improvement Act* (S.1486) would distinguish the role of LTCHs from other hospitals and post-acute providers and eliminate CMS’s LTCH 25% Rule, very short stay outlier policy, and CMS’s authority to impose a one-time budget neutrality adjustment. This summer, the 25% Rule is scheduled to resume with full implementation after a five-year regulatory moratorium authorized by Congress. While we continue to pursue congressional support for S. 1486, the AHA also is urging CMS to take administrative steps to delay the 25% Rule’s full implementation until legislation is passed to develop a long-term alternative to the 25% Rule.

Inpatient Rehabilitation Facilities. IRFs provide a distinct clinical value to Medicare beneficiaries that need inpatient acute rehabilitation services; and the

AHA will continue to oppose any proposals that would raise the threshold of the current IRF 60% Rule or pay skilled nursing rates for selected IRF cases. We will continue to highlight the stringent new Medicare patient criteria that ensure that IRFs are treating the appropriate patients, the flat cost curve for IRFs, and their positive clinical outcomes data. These data, combined with strict admissions criteria, ensure that patients with conditions that require both hospital-level medical management and intensive rehabilitation – complex conditions such as brain injury, spinal cord injury, and stroke – can continue to access IRF care.

Post-Acute Value-Based Purchasing. The AHA remains engaged in CMS’s processes to implement quality measures for IRFs and LTCHs. These include the ACA-mandated implementation of pay-for-reporting programs for both settings by October, which was initiated through a 2011 rulemaking by CMS. The AHA also is monitoring the post-acute component of the CMS/National Quality Forum comprehensive quality measurement planning process.

Post-Acute Care Payment Reform Demonstration (PAC-PRD). In February 2012, CMS issued to Congress the long-awaited report on its PAC-PRD demonstration, which was authorized in 2005 to develop a common patient assessment tool for all post-acute settings. The demonstration involved 140 general acute hospitals and post-acute providers in 11 markets. In the report, CMS states that the demonstration successfully produced an assessment instrument, called the “CARE Tool” that appears suitable for use in the post-acute settings (home health, skilled nursing, inpatient rehabilitation, and long-term care hospitals). The “CARE Tool” is described as desirable for standardized data collection across post-acute settings to compare function and other outcomes, develop better risk adjustment, and model new post-acute payment approaches, such as episode and site-neutral payment. The report does not include specific recommendations on reforms to the current post-acute fee-for-service payment systems for the post-acute silos. And CMS has stated since the release of the report that any further work on payment reforms related to the findings of this demonstration will require statutory authorization by Congress.