2012 priorities

On Capitol Hill

- Drug shortages
- Medicare Extenders
- HIT/multi-campus
- Annual appropriations

Medicare Extenders

Key Hospital Provisions

<table>
<thead>
<tr>
<th>Expiring Date</th>
<th>Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 31</td>
<td>Section 508 area wage index reclassifications</td>
</tr>
<tr>
<td>June 30</td>
<td>Treatment of technical component of physician pathology service</td>
</tr>
<tr>
<td></td>
<td>Reasonable cost reimbursement for laboratory services in small, rural hospitals</td>
</tr>
<tr>
<td></td>
<td>Long-term acute care hospitals 25% Rule</td>
</tr>
<tr>
<td>September 30</td>
<td>Payment adjustment for low-volume hospitals</td>
</tr>
<tr>
<td></td>
<td>Medicare-dependent hospital program</td>
</tr>
<tr>
<td>December 31</td>
<td>Hospital outpatient hold-harmless payments **</td>
</tr>
<tr>
<td></td>
<td>Increase in payments for ambulance services</td>
</tr>
<tr>
<td></td>
<td>Long-term acute care hospitals very short stay outlier policy</td>
</tr>
<tr>
<td></td>
<td>Long-term acute care hospitals budget-neutrality adjustment</td>
</tr>
</tbody>
</table>

*Policy applies to hospital cost reporting periods that begin as late as June 30, 2012. Therefore, policy could affect services furnished as late as June 30, 2013.
**Expires March 1, 2013 for sole community hospitals with more than 100 beds.
**Medicare extenders in current law**

**Expiring Provisions**

- Section 508 area wage index reclassifications
- Treatment of technical component of physician pathology services (Expires June 30)
- Reasonable cost reimbursement for laboratory services in small rural hospitals
- Increase payments for ambulance services (GAO report Oct 1, 2012 and MedPAC June 12, 2013)
- Hospital outpatient department hold-harmless payments (HHS Study July 1, 2012)
  - Eliminates for SCHs over 100 beds
- Medicare-dependent hospital**
- Low-volume adjustment**

* Expires September 30, 2012

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**MDH/Low-volume**

**The Rural Hospital Access Act (S.2620)**

Sens. Chuck Schumer(D-NY) and Chuck Grassley(R-IA)

Would extend the MDH program and the low-volume adjustment for one year to September 10, 2013.
Supreme Court Update

Our position

• Individual mandate is constitutional
• Medicaid expansions are constitutional
• Severability should be decided by the Supreme Court
• IF coverage expansions are thrown out…then budget cuts (update, DSH, and readmissions) must go
Post Election

Deficit Reduction

Fundamental questions:
- What will Medicare and Social Security look like?
- How big will the military be?
- How much will the wealthy pay in taxes?
- How will the country care for the sick and vulnerable (Medicaid)?

Payment reform...hospital role
- Specific policy options
What have we learned?

“Ground given up that may be hard to take back”

- Democrats on entitlements/beneficiaries
  - Harder to be guardians of Medicare in 2012
- Republicans on revenue/tax
  - Did they violate the “pledge”
- Supercommittee left no path forward

Rural Budget Deficit Implications

- 2011 CBO “options” document - $62B in savings if eliminate CAH, MDH, SCH
- FY2013 Pres. Obama Budget and proposal to “supercommittee”
  - Reduce CAHs payment of 101% of costs to 100%
  - Prohibit CAH designation for those CAHs that are less then 10 miles from nearest hospital
Seven months from now

End of this year

- Moratorium on Medicare physician cuts expire
- Payroll tax cut expires
- Bush tax cuts expire
- Sequester scheduled to kick-in
- Debt ceiling will need to be extended AGAIN

AHA Time for Opportunity

- Limited legislative engagements requiring broad-based grassroots action
  - Targeted approaches when necessary
- Preparation for post-election challenges
  - Laying the political foundation
  - Developing policy ideas/data
- Positioning hospitals as offering solutions
## “We Care...We Vote” Strategy

### Goals and Objectives

- Create political climate sympathetic to our concerns
- Influence congressional elections
- Broaden base of our support
**Campaign 2012**

**“We Care…We Vote”**

- Key Questions for Candidates
- Hospital Champions
- Resources and platforms
  - Challenging Q&A’s
    - Executive compensation
    - Pricing transparency
  - Web site (materials and information)
  - Social media applications

**Our message…education**

**Will the care be there? How can we ensure Medicare and Medicaid patients have access to care?**

- What are the challenges?
- What are hospitals doing to increase value and maintain access?
- What public policy changes are needed…and what should be avoided?
What Are the Challenges?

**Forces Increasing Costs**
- Labor
- Life-saving technology/Rx
- Older, sicker patients
- Redundant regulation
- Liability insurance
- Info technology
- Emergency readiness

**Forces Decreasing Revenue**
- Government payment
- Private payer pressure
- New care delivery models
- Rising uninsured

What Are Hospitals Doing?

*Hospitals are tackling these challenges*

- Safety & Quality
- Effective Care
- IT Investments

**Better Patient Care**
Public Policy Changes

Alternatives to consider…

Healthy solutions not harmful cuts

Public Policy Changes

Changes that should be avoided

- E&M code/HOPD (site neutral - payment) reductions
- GME reductions
- Retrospective coding offsets
- State provider assessment restrictions
- CAH: payment reductions and qualification criteria
- Reductions to bad debt
“We Care..We Vote” Strategy

Tools

- Materials, guides and presentations
- Available on-line
- Social media
- Challenging Q&A’s
- Legal dos and don’ts

“We Care…We Vote” Strategy

Implementation Schedule

- June: Official Launch
- Key Milestones:
  - July 4th
  - August recess
  - Labor Day
  - 30 day election countdown
Contact Information

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AHA Rural Regulatory Update
Joanna Kim, Sr. Assoc. Director
AHA Policy
May 21, 2012
Today’s Agenda

- FY 2013 Inpatient PPS Proposed Rule
- Area Wage Index
- HIT
- Physician Supervision
- MedPAC
IPPS Hospital Rulemaking

Inpatient PPS Proposed Rule

- Coding offset
- Market basket cuts
- Readmissions
- VBP
- SCH Proposals

Proposed Update for FY 2013

<table>
<thead>
<tr>
<th>ADJUSTMENT</th>
<th>IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflation rate (hospital market-basket)</td>
<td>+ 3.0%</td>
</tr>
<tr>
<td>PPACA productivity adjustment</td>
<td>- 0.8%</td>
</tr>
<tr>
<td>PPACA reduction</td>
<td>- 0.1%</td>
</tr>
<tr>
<td>Coding adjustments</td>
<td>- 2.7%</td>
</tr>
<tr>
<td>“Recoupment” coding cut added back in</td>
<td>+ 2.9%</td>
</tr>
<tr>
<td>Outlier Budget Neutrality</td>
<td>- 0.9%</td>
</tr>
<tr>
<td>Readmissions reduction program</td>
<td>-0.3%</td>
</tr>
<tr>
<td>MDH/Section 508 Expirations</td>
<td>-0.2%</td>
</tr>
</tbody>
</table>

NET UPDATE FACTOR + 0.9%
**Readmissions Reduction Program**

- CMS will use existing 30-day readmissions measures: heart attack, heart failure, pneumonia
- ACA: exclude unrelated, planned
- Hospitals with fewer than 25 discharges for each condition be excluded
- Hospitals with “excess” readmissions penalized on per-claim basis

<table>
<thead>
<tr>
<th>Readmission Penalty</th>
<th>Percent of PPS Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 percent</td>
<td>34.5</td>
</tr>
<tr>
<td>0 - 0.49 percent</td>
<td>36.3</td>
</tr>
<tr>
<td>0.5 – 1.0 percent</td>
<td>29.2</td>
</tr>
</tbody>
</table>

**Value-based Purchasing**

- FY 2013 payment based on:
  - **HCAHPS 30%**
  - 12 Process Measures 70%
- Performance measured from July 2011 – March 2012
- CMS proposes to reduce the base operating payment on each claim by 1 percent for hospitals eligible for the VBP program.
- It proposes to apply the hospital’s VBP incentive amount to each claim at the same time.
  - Hospitals performing exactly equal to the average will have 1 percent withheld, 1 percent added on.
- Details on low-volume exclusions, preliminary scores in August final rule
Sole Community Hospitals

- Flexibility for MDHs to obtain SCH status upon end of MDH program, instead of 30 days after CMS’s approval of SCH status
- Currently, SCH classification indefinite – unless change in qualifying criteria
  - If a hospital never should have qualified for SCH status in the first place, CMS proposes they can revoke status retroactively to date it was granted
AHA Area Wage Index Taskforce

- AHA Wage Index Chart Pack released in November
- AHA Wage Index Taskforce met in November, January and April
- CMS recommendations on wage index reform issued in April
- AHA Wage Index Website: www.aha.org/wageindex
- IOM report on impact of 2011 proposals in expected June 2012

AHA Area Wage Index Taskforce

November Meeting

- Taskforce charge and discussion of key concerns
- Presentations by IOM, CMS and MedPAC
AHA Area Wage Index Taskforce

January Meeting

- Presentation on Bureau of Labor Statistics wage data
- Taskforce discussion of key data issues:
  - Comparison of cost report to BLS
  - Frequency of reporting
  - Consistency
  - Circularity
  - Data priorities

| Please rank the data characteristics below in order of importance for use in the wage index |
| ----------------------------------------------- | --- |
| Accuracy and consistency                      | 1  |
| Hospital reports                               | 2  |
| Hospital data only                             | 3  |
| Non-medicare benefits                          | 4  |
| Include contract labor                         | 5  |
| Fully adjusted for occupational mix           | 6  |
| Standardized to account for full- and part-time employees | 7  |
| Available in a timely manner                   | 8  |
| Updated at least annually                      | 9  |
| Fully transparent and auditable                | 10 |
| Minimize variability                           | 11 |
| Minimize administrative burden                 | 12 |

AHA Area Wage Index Taskforce

April Meeting

- Task Force discussed:
  - Reclassification
  - Geographic boundaries
  - Labor share
  - Preliminary principles
**AHA Area Wage Index Taskforce**

**Next Steps**

- Held May conference call to refine preliminary principles and CMS report
- Will discuss principles at summer and possibly fall round of RPBs
- Report to the Board in November

**Update On EHR Incentive Programs**

- Medicare and Medicaid EHR incentive program registrations:
  - 3,247 Hospitals
  - About 188,400 Physicians/EPs
- A growing number, but still small share, have been paid for meeting meaningful use requirements
  - 712 Hospitals (40 CAH)
  - 22,937 Physicians
- 43 states have opened Medicaid programs

*Data from CMS, as of January 2012*
Trends in Program to Date Payments, in millions, FY-2011 through January 2012

Payments to eligible professionals and hospitals under the Medicare and Medicaid EHR incentive programs

- **Medicaid**
  - FY-2011: $860.1 m
  - Oct.: $502.7
  - Nov.: $711.6
  - Dec.: $920.3
  - Jan.: $1,420.5

- **Medicare**
  - FY-2011: $1,239.1 m
  - Oct.: $527.5
  - Nov.: $1,836.3 m
  - Dec.: $1,384.2
  - Jan.: $1,698.8

Data from CMS, as of end-January 2012.

Most, but not all, states have now established Medicaid EHR incentive programs

- **Red** = Made Payments (34)
- **Blue** = Accepting Registrations (9)

Data from CMS as of January 2012

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Meaningful Use of EHRs: Stage 2 Proposed Rule

- 20 hospital objectives, including 5 new objectives
- Hospitals must meet 16 core objectives and 2 of 4 menu set objectives
- Hospitals electronically generate and report on 24 clinical measures from a menu of 49 using certified EHR technology
- Implement Medicare payment penalties in FY 2015:
  - based on FY 2013 meaningful use status for PPS hospitals
  - based on FY 2015 meaningful use status for CAHs

CY 2012 Medicare OPPS Final Rule

- Issued November 1
- Key Issues
  - Physician Supervision
  - Extenders
Supervision of Outpatient Therapeutic Services

- Established APC Panel as independent review body to review requests for re-assignment of supervision levels
  - Added several CAH representatives to Panel
- Panel will re-assign supervision levels both up (i.e. personal) or down (i.e. general) from current (i.e. direct)
  - Must consider clinical, payment and quality context & likelihood that patients’ care would need to be modified by supervisor
  - Must consider service’s complexity, acuity of patient population receiving service, probability of unexpected/adverse event, expectation of rapid clinical changes during procedure.

Supervision, continued

- CMS final decisions on recommendations handled through sub-regulatory process
  - Posting on CMS Web site
  - Only informal public comment accepted.
- Since policy decisions on many key services until mid-2012, CMS further delayed enforcement of through CY 2012 of supervision requirements in CAHs and small rural hospitals with 100 or fewer beds.

NOTE: CMS states that extension is intended to allow these hospitals time to meet the direct supervision standard while policy alternatives are debated.
**Supervision, continued**

- February 14, CMS appointed additional members of Panel
- February 27-28: Supervision Panel Met
  - Recommended 24 CPT codes be downgraded from direct to general supervision
  - Recommended 3 HCPCS codes be downgraded from direct to general supervision
  - Recommended 1 CPT code be added to list of “nonsurgical extended duration therapeutic services” (inhalation treatment)
- Many psychotherapy, immunization codes
- Also, insertion of non-indwelling bladder catheter and smoking/tobacco cessation counseling

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**Supervision, continued**

- April 24: CMS publishes preliminary decisions
  - Recommended 24 CPT codes be downgraded from direct to general supervision
  - Recommended 3 HCPCS codes be downgraded from direct to general supervision
  - Recommended 1 CPT code be added to list of “nonsurgical extended duration therapeutic services” (inhalation treatment)
- Many psychotherapy, immunization codes
- Also, insertion of non-indwelling bladder catheter and smoking/tobacco cessation counseling
Supervision, continued

• Next Steps:
  – Public comments on CMS’s preliminary decisions may be sent via email to HOPSupervisionComments@cms.hhs.gov by May 19th
  – Panel meet in Fall and comment on OPPS proposed rule
  – Also review additional codes

MedPAC Rural Report

Principles for Rural Quality

• Quality of care in rural and urban areas should be equal for non-emergency services rural providers choose to deliver
• Quality of emergency care may differ between rural and urban areas due to limitations of small rural hospitals and the necessity to treat the patient at the rural facility
• All providers should be evaluated on all the services they provide and the data should be publicly reported
MedPAC Rural Report

Principles for Rural Payment Adjustments

- Target providers to low-volume isolated providers that are a certain distance from other providers
- Payments should be empirically justified
- Maintain incentives for cost control

Contact Information

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