



## 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) 2013 will be negative 6.0 percent.

At the same time, hospitals continue to 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. Equally troubling, hospitals are grappling with a 2 percent automatic reduction in Medicare payments, which took effect April 1 as a result of the *Budget Control Act's* sequester. Hospitals need adequate Medicare payment to ensure that patients and communities receive the care they expect and need.

### AHA View

The sequester is the latest example of the federal government's reliance on arbitrarily ratcheting down provider payments to address concerns about health care spending, the deficit and related budget issues. But, ratcheting provider payments will not put the nation on a sustainable path for the future; we need real reforms, not blunt cuts to providers. A new AHA report, "Ensuring a Healthier Tomorrow," proposes targeted reforms that can improve the way we deliver care, slow the growth in health care spending and build a stronger foundation for the future. The report focuses on two interconnected strategies – promote and reward accountability, and use limited health dollars wisely. Each of the 12 recommendations has an associated list of suggested actions that providers, the government, insurers and employers, and patients can take to strengthen our health care system and our nation's finances. Together, they provide a starting point for how – working together – all stakeholders can ensure a healthier tomorrow. The report is available at [www.aha.org/healthiertomorrow](http://www.aha.org/healthiertomorrow).

**Inpatient PPS Rule.** The AHA anticipates that, in the FY 2014 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 2014 inpatient PPS proposed rule (expected in late April), CMS will propose a temporary documentation and coding cut to comply with the *American Taxpayer Relief Act (ATRA)*, which extends the period for which CMS must recoup alleged overpayments through FY 2012.

CMS must do so by making a temporary adjustment to the inpatient PPS over a four-year period. If CMS implements the cuts evenly over the four years, the reduction would be about 2.4 percent in FY 2014, and would remain in place through FY 2017. The reduction would then be restored in FY 2018. The agency also may re-propose the permanent documentation and coding cut of 0.8 percent that it withdrew in its FY 2013 inpatient PPS final rule due to our advocacy efforts. **Nevertheless, the AHA continues to assert that CMS has used a flawed methodology and is overstating the effect of the documentation and coding change.**

Disproportionate Share Hospital (DSH) Payments. The AHA also expects CMS to propose how it will implement changes to DSH payments, as mandated by the ACA. In FY 2014, the ACA begins reducing DSH payments to 25 percent of what hospitals would have received under the current formula. The basic elements of the Medicare DSH program – the designation criteria, the payment calculation methodology and the application of payment to the DRG – remain. Much of the savings generated by this change will then be used to supply a new pool of funds for Medicare DSH hospitals, with the size of the new DSH pool based on the decrease in the non-elderly uninsured population. Medicare DSH hospitals will receive additional payments from the new DSH pool based on their share of national uncompensated care for all Medicare DSH hospitals. The AHA will work to ensure that the modifications to the Medicare DSH program are made in accordance with the DSH principles adopted by the AHA Board of Trustees.

Patient Status. The AHA anticipates that CMS also will address the issue of patient status in its FY 2014 inpatient PPS rule. Whether a patient is admitted to a hospital as an inpatient or treated under outpatient observation status has implications for Medicare payment and Medicare beneficiary coverage. Traditionally, the decision to admit a patient as an inpatient has been up to the judgment of the treating physician, with oversight from the hospital and input from the patient. CMS recovery audit contractors and Medicare administrative contractors have started to second guess physician judgment, declaring that some patients who were admitted should not have been. The second-guessing has created ambiguity over who decides what constitutes an appropriate admission and what the criteria are for making such a determination.

In the calendar year (CY) 2013 hospital outpatient PPS rule, CMS requested feedback on potential policy options to address this issue, including:

- Establishing time-based admission policies, such as automatic inpatient admission after a patient has been receiving outpatient observation services for 24 or 48 hours;
- Adopting more specific clinical criteria and measures for inpatient admission;

- Using prior authorization for admissions where hospitals would know in advance that a service is approved and that the claim will be paid; and
- Exploring changes to payment policy to better align payment to the intensity of resources used in the care of patients.

In comments to CMS, the AHA described the advantages and disadvantages for each potential policy option but did not recommend one particular option. In its final CY 2013 outpatient PPS rule, CMS did not finalize an approach or reveal a preference among the policy options. We anticipate CMS will address the patient status issue in its FY 2014 inpatient PPS rule. When this occurs, the AHA will conduct further discussions with members to analyze the impact of CMS's proposal for inclusion in our comment letter.

**Area Wage Index.** Hospitals repeatedly have expressed concern that the inpatient PPS area wage index is greatly flawed in many respects. Members of Congress and Medicare officials also have concerns with the present system. In response to these growing concerns, there has been a great deal of activity around the hospital wage index. In 2007, MedPAC developed an alternative wage index framework. In June 2011, the Institute of Medicine (IOM) issued a report containing recommendations for CMS on the wage index. In April 2012, CMS issued a congressionally mandated report on an alternative area wage index methodology. All of the proposals – MedPAC, IOM and CMS – would require legislative action for adoption.

In July 2011, the AHA Board of Trustees created a Medicare Area Wage Index Task Force to identify and evaluate the strengths and weaknesses of the current hospital wage index; develop a set of principles by which to evaluate various proposals to modify the hospital wage index, including review of AHA's existing principles; evaluate proposals and studies to change the hospital wage index; and make recommendations to improve the accuracy, fairness and effectiveness of the hospital wage index.

The task force has engaged in an extensive amount of education, analysis and discussion about the wage index system. They identified five major issues that must be addressed to improve the wage index system: accuracy and consistency; volatility; circularity; reclassifications and exceptions; and labor markets. They agreed to nine principles and made seven recommendations to the AHA Board of Trustees to reform the wage index. The task force members agreed that it is unlikely that any set of recommendations would completely "fix" the wage index system for the hospital field. However, they felt very strongly that there are specific actions that would categorically improve the system for the field as a whole.

**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 weaken 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 weaken 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 the CY 2009-2013 outpatient PPS rules, CMS mandated new requirements for “direct supervision” of outpatient therapeutic services. Direct supervision requires that a physician or a non-physician practitioner be immediately available to furnish assistance or direction throughout the performance of the procedure. Small, rural PPS hospitals and critical access hospitals (CAHs) have expressed concern that shortages of physician and non-physician practitioners in their communities make it difficult to comply with the direct supervision requirements. For CY 2013, as requested by the AHA, CMS again extended its policy not to enforce the direct supervision policy for therapeutic services provided in CAHs and rural hospitals with 100 or fewer beds. CMS expects this to be the final year of the enforcement moratorium and encourages hospitals to use the time to come into compliance with the supervision standard. CMS notes that the extension also will provide additional opportunities for stakeholders to bring their issues to the Advisory Panel on Hospital Outpatient Payment (HOP Panel) and for the panel to evaluate and provide recommendations on supervision of outpatient therapeutic services.

The HOP Panel is charged with assessing the appropriate supervision levels for individual hospital outpatient therapeutic services. As a result of the panel’s input, CMS in 2012 reduced the level of supervision for 49 outpatient therapeutic services. Two HOP Panel meetings are scheduled in 2013; one in March and one in late summer. However, no hospitals requested to make a supervision presentation to the HOP Panel at the March meeting. **Given the importance of this issue to the field, we strongly encourage hospitals to consult with their clinical staff and request an opportunity to testify before the HOP Panel’s summer meeting regarding additional services that could safely be downgraded to general supervision.** The AHA will issue a *Regulatory Action Alert* and other reminders when the summer meeting is announced.

Furthermore, while the AHA appreciates CMS’s efforts to make the requirements more flexible, we continue to be concerned that hospitals and CAHs will have difficulty implementing these requirements, and timely access to services will

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

- Adopt a default standard of “general supervision” for outpatient therapeutic services and then apply reasonable exceptions to identify specific procedures that should be subject to direct supervision;
- Ensure that for CAHs, the definition of “direct supervision” is consistent with the CAH conditions of participation that allow a physician or non-physician practitioner 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 Jan. 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.

However, some policymakers are advocating for a significant reduction in Medicare graduate medical education (GME) payments to teaching hospitals. Specifically, the president’s 2011 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. The Simpson-Bowles Deficit Reduction Commission recommended reducing the IME adjustment by 60 percent and limiting hospitals’ direct GME payments to 120 percent of the national average salary paid to residents in 2010. The Simpson-Bowles changes would reduce Medicare medical education payments by an estimated \$60 billion through 2020. Recently, CMS reduced IME payments by \$40 million in FY 2013 by including labor and delivery beds in the IME calculation.

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.** For more information, see the AHA’s issue paper “Annual Appropriations.”

Given the current and projected shortage of physicians, especially in primary care and general surgery, the AHA continues to recommend that the 1996 cap on residency slots be lifted. Limits on the number of Medicare-funded residency

training slots constrain the ability of hospitals to train new physicians. That's why the AHA supports the *Resident Physician Shortage Reduction Act of 2013* (S. 577/H.R. 1180), introduced by Sens. Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV), and by Rep. Joe Crowley (D-NY), respectively. The bill would increase the number of Medicare-supported physician training positions to at least 15,000 new resident positions, which is about a 15 percent increase in residency slots.

**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 ATRA. However, this law did not go nearly far enough in extending policies critical to rural hospitals. In 2013, we continue to work with Congress to provide small, rural hospitals with adequate reimbursement, including extension of rural provisions.** For more information, see the AHA's issue paper "Small or Rural Hospitals."

#### POST-ACUTE CARE

**Long-term Care Hospitals (LTCH).** The AHA continues to advocate for more stringent patient and facility criteria for LTCHs in order to ensure that they have a distinct role in the continuum of care. The criteria proposal in the previously introduced *Long-Term Care Hospital Improvement Act* was refined in 2012 through further AHA member input and guidance. The AHA is urging action by Congress on this refined proposal. Our advocacy efforts include the critical goal of securing relief from CMS's onerous and arbitrary "25% Rule." Following a limited extension of 25% Rule relief, full implementation of the 25% Rule is scheduled to resume this summer. In addition, we continue to communicate with CMS and MedPAC on analyses demonstrating the unique and valuable role LTCHs have for beneficiaries with the highest levels of medical severity.

**Inpatient Rehabilitation Facilities (IRF).** IRFs provide a distinct clinical value to Medicare beneficiaries who need both intensive rehabilitation and hospital-level care. The uniqueness of IRFs is ensured by several policies, including the IRF "60% Rule" and stringent Medicare patient criteria that restrict IRF admissions to patients requiring hospital-level care including physician oversight. These policies have led to a flat curve for Medicare IRF payments and a dramatic drop in overall volume of IRF cases. IRFs also obtain extremely positive clinical outcomes, such as lower readmissions rates and higher discharges to community. Thus, the AHA will continue to oppose any proposals to raise the threshold of the IRF 60% Rule or to pay skilled-nursing rates for selected IRF cases. Access to IRF care must be ensured for beneficiaries who clinically require the unique combination of hospital-level care and intensive rehabilitation, such as brain injury, spinal cord injury and stroke patients.