American Hospital Association®

# A Special Message

## Fall Legislative & Regulatory Agenda

**Congress returns this fall with a full slate. Among the most-pressing issues it will need to tackle are three potential fiscal flashpoints:**

- Passing a continuing resolution for fiscal year 2014, which begins Oct. 1;
- Authorization of an increase in the nation's borrowing authority (the debt ceiling) sometime around mid-late October; and
- A fix for the physician payment formula before the end of the year.

**As lawmakers get back to business, the AHA is working to ensure that the voice of hospitals – and the patients and communities they serve – is heard. Specifically, we are:**

- **Working for passage of critical hospital-related legislation** that will help hospitals continue to fulfill their mission of caring;
- **Protecting hospital payments** as legislators look for savings and potential offsets for other spending; and
- **Advocating for needed regulatory changes** to increase efficiency and ease the burden on hospitals so that staff can spend more time and resources caring for patients.

**The AHA will continue to advocate strongly on hospitals' behalf with Congress and the federal regulatory agencies to ensure that hospitals have the resources they need to provide care to their patients and communities. Across the coming weeks, there will be many opportunities for you to be involved:**

- **Watch for *AHA Action Alerts*** on steps you can take to reach out to legislators and regulators to amplify the hospital message.
- **Join the *AHA Advocacy Alliances*** on issues of particular interest to your organization. Click here for more information about our five alliances.
- **Plan to attend an *AHA Advocacy Day.*** Click here for more details.
- **Visit the *AHA Action Center*** for additional news and updates, including updates to our congressional scorecard. Click here for more.

9/30/13

# Key Legislative Issues

| AHA-Supported Bill | What It Would Do | Resources |
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| **The Medicare Audit Improvement Act** | Introduced by Reps. Sam Graves (R-MO) and Adam Schiff (D-CA) and by Sens. Mark Pryor (D-AR) and Roy Blunt (R-MO), respectively, this bill would establish a consolidated limit for medical record requests, impose financial penalties on RACs that fail to comply with program requirements, make RAC performance evaluations publicly available and allow denied inpatient claims to be billed as outpatient claims when appropriate. | Bill Language:<br>• H.R. 1250<br>• S. 1012<br>AHA Letter of Support<br>AHA Action Alert<br>AHA Factsheet<br>List of Co-sponsors |
| **The DSH Reduction Relief Act** | Introduced by Rep. John Lewis (D-GA) and Sen. Roger Wicker (R-MS), this bill would eliminate the first two years of the ACA's cuts to the Medicare and Medicaid DSH programs to allow expansion of health coverage to become more fully realized. | Bill Language:<br>• H.R. 1920<br>• S. 1555<br>AHA Letter of Support<br>AHA Action Alert<br>AHA Factsheet<br>List of Co-sponsors |
| **The Fairness in Health Care Claims, Guidance and Investigations Act** | Introduced by Reps. Howard Coble (R-NC) and David Scott (D-GA), this bill would amend the False Claims Act by: requiring that federal agencies review their own rules and regulations to determine whether a billing dispute should be pursued as fraud before launching an investigation, and assuring that unintentional billing disputes aren't penalized as harshly as fraud. | Bill Language:<br>• H.R. 2931<br>AHA Letter of Support<br>AHA Factsheet |
| **The Rural Hospital Access Act** | Introduced by Sens. Charles Schumer (D-NY) and Charles Grassley (R-IA) and by Reps. Tom Reed (R-NY) and Peter Welch (D-VT), respectively, this bill would provide for an extension of the Medicare-dependent hospital program and payments under the Medicare low-volume hospital program. | Bill Language:<br>• S. 842<br>• H.R. 1787<br>AHA Letter of Support<br>AHA Action Alert<br>AHA Factsheet<br>List of Co-sponsors |
| **The Protecting Access to Rural Therapy Services Act** | Introduced by Sen. Jerry Moran (R-KS) and by Reps. Kristi Noem (R-SD) and Collin Peterson (D-MN), respectively, this bill would protect access to outpatient therapeutic services by adopting a default standard of "general supervision" (rather than "direct supervision") for outpatient therapeutic services; creating a provider advisory panel to identify those outpatient services complex enough to require direct supervision; and holding hospitals and CAHs harmless from civil or criminal action regarding CMS's retroactive reinterpretation. | Bill Language:<br>• S. 1143<br>• H.R. 2801<br>AHA Letter of Support<br>AHA Action Alert<br>AHA Factsheet<br>List of Co-sponsors |

# Areas at Risk for Payment Reductions

| Area of Vulnerability | AHA Position | Resources |
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| **Cuts to payments for evaluation and management services and certain other procedures provided in hospital outpatient departments (HOPDs)** | Three potential site neutral payment changes have been proposed that would result in lower payments to hospitals:<br>• paying for evaluation and management services in the HOPD setting at the physician fee schedule amount, a cut of about 70%;<br>• paying for 66 ambulatory payment classifications in the HOPD at the physician fee amount; and<br>• capping payment for 12 procedures commonly performed in the ambulatory surgical center (ASC) setting at the ASC rate when done in the HOPD.<br>HOPDs have higher cost structures than physician offices due to the need to have emergency stand-by capacity and the unique regulatory requirements imposed on them. Medicare margins are negative 11% for outpatient services. Making additional cuts to HOPD payments threatens beneficiary access to these services. | AHA Factsheet on E&M<br>AHA Factsheet on Site-Neutral Payment<br>AHA Infographic<br>AHA Letter to MedPAC<br>AHA Alliance for Coordinated Care |
| **Reductions to payments for graduate medical education (GME)** | Reductions in Medicare funding for indirect medical education and direct GME would jeopardize the ability of teaching hospitals to train the next generation of physicians and limit the ability of teaching hospitals to offer state-of-the-art clinical and educational experiences. AHA also urges Congress to eliminate the 17-year freeze in the number of physician training positions Medicare funds by supporting the creation of at least 15,000 new resident positions (about a 15% increase in residency slots) as included in the *Resident Physician Shortage Reduction Act of 2013* (S. 577). | AHA Factsheet<br>AHA Alliance for Graduate Medical Education |
| **Changes to the 340B Drug Discount Program** | The 340B program is essential to helping safety-net providers stretch limited resources to better serve their communities. We support the continuation of this essental program, which saves money for providers and state and federal governments. The AHA supports program integrity efforts but will continue to oppose efforts to scale back this program. | AHA Factsheet<br>AHA Advocacy Alliance for the 340B Discount Drug Program |

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| Area of Vulnerability | AHA Position | Resources |
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| **Reductions in payments to hospitals for assistance to low-income Medicare beneficiaries (bad debt)** | The Medicare program already pays less than the cost of providing care to Medicare beneficiaries. Reductions exacerbate this problem, especially for those hospitals that serve many low-income beneficiaries. Cutting reimbursement to hospitals for assistance to cover the debts of low-income Medicare beneficiaries while still paying less than the cost of care to Medicare beneficiaries is unfair. | AHA Factsheet |
| **Changes to the critical access hospital (CAH) program)** | Congress and the administration have called for reduced CAH payments and the elimination of CAH designation based on mileage between CAHs and other hospitals. These proposals are misguided and demonstrate an unfortunate lack of understanding of how health care is delivered in rural America. These hospitals are the primary source of health care for the uninsured and underinsured and provide vital resources in times of emergencies. Many facilities may be forced to close and patients could lose their access to essential medical services if the program is altered. | AHA Factsheet<br>AHA Alliance for Rural Hospitals |
| **Restrictions on Medicaid provider assessments** | Provider assessment cuts are just another name for Medicaid cuts and harm the millions of children, poor and disabled Americans who rely upon this vital program. Medicaid, on average, covers only 95 cents of every dollar spent treating Medicaid patients. Further cuts to hospital funding would put enormous pressure on already stretched state budgets and could jeopardize this essential health care safety-net program. | AHA Factsheet<br>AHA Alliance for Provider Assessments |

# Key Regulatory Issues

| Issue | AHA Position | Resources |
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| **Centers for Medicare & Medicaid Services' (CMS) policy on rebilling Medicare Part A claims** | CMS finalized a policy that allows hospitals to rebill under Part B for most services after a Part A claim has been denied because the admission was found not reasonable and necessary. However, the Part B claim must be submitted within one year of the date of service. The AHA is extremely disappointed that CMS's ruling does not fundamentally reform its policy on rebilling and continues to deny hospitals reimbursement for reasonable and necessary services they provide to their Medicare patients. **The AHA plans to press ahead with the rebilling litigation we initiated last year.** Further, the AHA continues to urge Congress to support changes included in the *Medicare Audit Improvement Act* (H.R. 1250/S. 1012). | AHA Regulatory Advisory<br>AHA Comment Letter to CMS<br>AHA Rebilling Litigation<br>Factsheet on H.R. 1250/S. 1012 |
| **CMS implementation of "two-midnight" policy regarding patient status** | CMS finalized its policy related to admission and medical review criteria under Medicare Part A, including its two-midnight benchmark and presumption. The two-midnight benchmark is guidance for admitting practitioners to identify when an inpatient admission is generally appropriate for payment; and the two-midnight presumption instructs Medicare contractors to presume that hospital claims with lengths of stay greater than two midnights after a physician order for admission are reasonable, necessary and generally appropriate for Part A payment. While CMS has provided clarification regarding when an inpatient admission is appropriate (presumption), we are concerned that this policy will not sufficiently reduce the number of appeals of Part A claim denials – particularly if the guidance issued by CMS is not precisely written and enforced – and, more importantly, could be applied in a manner that undermines medical judgment. CMS will accept provider feedback at *IPPSAdmissions@cms.hhs.gov*. AHA will:<br>• advocate with CMS for timely implementation of the two-midnight presumption, but delay enforcement of the elements of this rule that need further guidance from CMS and additional time for hospitals to operationalize (i.e., the physician order requirements and two-midnight benchmark);<br>• influence CMS to shape its guidance and ensure consistent application of the new policies across providers and Medicare contractors;<br>• advocate with CMS to explore a payment approach that aligns payment rates to the resources utilized to furnish services;<br>• work to correct issues and problems in the new policy as they arise; and<br>• continue to urge Congress to support changes included in the *Medicare Audit Improvement Act* (H.R. 1250/S. 1012). | AHA Regulatory Advisory<br>AHA Comment Letter to CMS<br>Factsheet on H.R. 1250/S. 1012 |

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| Issue | AHA Position | Resources |
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| **Realignment of Meaningful Use Stage 2 requirements to ensure a safe, orderly transition** | The Department of Health and Human Services (HHS) should extend and make more flexible the meaningful use timelines for the Medicare Electronic Health Record (EHR) Incentive Program to ensure a safe, orderly transition to the next phase of the program that leaves no health care providers behind. Specifically, HHS should:<br>• allow providers at Stage 1 to meet requirements using either the 2011 or 2014 certified Edition EHR;<br>• extend each stage of meaningful use to no less than three years for all providers;<br>• establish a 90-day reporting period for the first year of each new stage of meaningful use for all providers;<br>• offer greater flexibility to providers in meeting Stage 2; and<br>• redirect the electronic clinical quality reporting requirements to focus on a small set of well-tested measures. | AHA-AMA Letter to HHS<br>AHA Statement to the Senate Finance Committee<br>AHA Comment Letter to ONC<br>AHA Comment Letter to CMS<br>eCQM Study |
| **Modifications to the Hospital Readmissions Reduction Program (HRRP)** | America's hospitals are focused on reducing unnecessary readmissions. However, the HRRP must be reformed to:<br>• adequately account for socioeconomic factors;<br>• correct the flawed payment formula; and<br>• appropriately exclude unrelated readmissions from the penalty. The formula not only penalizes hospitals more than Congress intended, it wrongly penalizes hospitals for making improvements. | AHA Factsheet<br>AHA Comment Letter<br>Hospital Engagement Network Readmissions Work |
| **Changes to the Hospital-acquired Condition (HACs) Reduction Program** | While we support programs to eliminate patient harm from HACs, this program is neither well-conceived or designed. We urge CMS to delay finalizing the HAC program, as we have significant concerns about the measures and scoring methodology. | AHA Comment Letter |
| **CMS proposal to end the moratorium on enforcement of the direct supervision for outpatient therapeutic services provided in CAHs and small rural PPS hospitals with 100 or fewer beds** | The AHA is disappointed that CMS has not heeded the concerns voiced by CAHs and small rural hospitals that requiring adherence to the direct supervision requirements for outpatient therapeutic services is not only unnecessary but will reduce access to care. Due to unabated shortages of physicians and non-physician practitioners in rural communities, compliance with the direct supervision requirements means that many hospitals will have no choice but to limit their hours of operation or close certain programs. (See Key Legislative Issues for more.) | AHA Factsheet<br>AHA Comment Letter to CMS<br>AHA Regulatory Advisory<br>S. 1143<br>H.R. 2801 |

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| Issue | AHA Position | Resources |
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| **Appropriate reforms for long-term care hospitals (LTCHs)** | Full implementation of the "25% Rule" will begin for cost reporting periods beginning on or after Oct. 1. This arbitrary policy will reduce payments based on the origin of the LTCH referral, with no regard for the patient's medical necessity for LTCH services, and presents a severe operational and fiscal challenge for many LTCHs.<br><br>Also, CMS has been conducting payment reform research that, if implemented, would dramatically reduce the population of patients eligible for LTCH-level payment – payments would be reduced to inpatient PPS-comparable rates for more than 65% of the current LTCH patient population. If applied as a payment policy, this would radically reduce access to the specialized LTCH setting. We continue to advocate for appropriate reforms, including clinically-based patient admission criteria that include all high-acuity, long-stay patients. | AHA Factsheet<br>AHA Regulatory Advisory<br>AHA Comment Letter to CMS<br>AHA Letter to MedPAC<br>AHA Letter to Congressional Leaders |
| **Medicare Advantage organizations' (MAOs) handling of sequestration cuts** | We are concerned that many MAOs are erroneously passing along to hospitals a 2% reduction in contracted payment amounts without regard to the terms of their contracts with those providers. We urge CMS to provide additional guidance to MA plans clarifying that Medicare rates themselves have not been altered by sequestration and that CMS has not issued a "default Medicare rate" that incorporates a 2% reduction. | AHA Letter |
| **Qualified Health Plan (QHP) payment for services during grace period for nonpayment of premiums** | We urge CMS to ensure compliance with the ACA by requiring QHPs to provide health insurance coverage for a full three-month grace period. Specifically, we ask that CMS require QHPs in the exchanges to pay providers for services they delivered to federally subsidized individuals who cease paying their share of premiums during the required 90-day grace period for coverage. | AHA Letter |