Outpatient Evaluation & Management Services

THE ISSUE

Congress is considering a 2011 Medicare Payment Advisory Commission (MedPAC) recommendation that would cap “total” payment for non-emergency department evaluation and management (E/M) services in hospital outpatient departments (HOPDs) at the rate paid to physicians for providing the services in their private offices.

However, in the 2014 outpatient prospective payment system (PPS) final rule, the Centers for Medicare & Medicaid Services (CMS) collapsed the 10 separate E/M codes for hospital outpatient clinic visits, and replaced them with one new code representing a single level of payment for all outpatient clinic visits. The previous clinic visit codes reflecting five levels of resource intensity and the distinction between new and established patients are no longer recognized in the outpatient PPS. The adoption of a single code for all hospital outpatient clinic visits means a one-to-one coding match no longer exists to implement MedPAC’s recommendation. MedPAC has not revisited its recommendation or its impact analysis since CMS finalized the E/M code collapse policy.

MedPAC had estimated its policy would reduce Medicare spending by $900 million per year and $9 billion over 10 years, by reducing hospital payment between 65 percent and 80 percent for 10 of the most common outpatient services.

AHA POSITION

Given CMS’s sweeping changes to the coding structure for E/M hospital outpatient clinic visit services, it is unclear how Congress could enact MedPAC’s ill-advised prior recommendation to equalize Medicare payment rates for E/M services between HOPDs and physician office settings. However, even if it is possible, the AHA strongly opposes such legislation because:

- Hospitals provide access to critical hospital-based services that are not otherwise available in the community and treat higher-severity patients for whom the hospital outpatient department is the appropriate setting.
- Hospitals have higher cost structures than physician offices due to the need to have emergency stand-by capacity.
- Hospitals have more comprehensive licensing, accreditation and regulatory requirements than physician offices.

WHY?

- Hospitals already lose money treating Medicare patients in HOPDs. According to MedPAC’s June 2014 Data Book, Medicare margins were negative 11.2 percent for outpatient services in 2012. Additional cuts to HOPDs threaten beneficiary access to these services.

- Patients who are too sick for physician offices are treated in HOPDs. Physicians refer more complex patients to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices, HOPDs treat patients with a higher average risk for complications.
  - An AHA analysis of Medicare data demonstrates that patient severity for E/M clinic visits, as measured using weighted hierarchical condition categories (HCC) scores, is nearly 24 percent higher in HOPDs than in physician offices.
Hospitals have greater costs than physicians providing the same service in their offices. HOPDs must comply with a much more comprehensive scope of licensing, accreditation and other regulatory requirements than do free-standing physician offices. CMS acknowledged this in its July 19 proposed rule for the 2014 physician payment system:

“When services are furnished in the facility setting, such as a hospital outpatient department (OPD) or an ambulatory surgical center (ASC), the total Medicare payment (made to the facility and the professional combined) typically exceeds the Medicare payment made for the same service when furnished in the physician office or other nonfacility setting. We believe that this payment difference generally reflects the greater costs that facilities incur than those incurred by practitioners furnishing services in offices and other non-facility settings. For example, hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in physician offices, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Additionally, hospitals and ASCs must meet Medicare conditions of participation and conditions for coverage, respectively.”

Unpaid “stand-by capacity” costs – such as around-the-clock availability of emergency services; cross-subsidization of uncompensated care, EMTALA and Medicaid; emergency back-up for other settings of care; disaster preparedness; a wide range of staff and equipment – make hospital-level care more expensive, and these costs are spread across all hospital services, including outpatient E/M services.

Teaching and safety-net hospitals would be hardest hit by the cuts. Of special concern is the disproportionate impact that this policy would likely have on major teaching hospitals and public hospitals. Impact data from before CMS changed the clinic visits coding structure show that, while the overall cut to U.S. hospitals would be 2.8 percent, the impact more than doubles for major teaching hospitals, which would face a 5.6 percent cut, and in urban, public safety-net hospitals, which would face a 4.6 percent cut.

Payment should reflect HOPD costs, not physician payments. HOPD payment rates are based on hospital cost report and claims data. In contrast, the physician payment schedule (and specifically the practice expense component) is based on voluntary responses to physician survey data held flat for years due to the cost of various physician payment “fixes.”

Capping E/M payment would lead to distortion of the hospital outpatient payment system. Capping E/M payment as proposed would lead to significant distortions in the outpatient ambulatory payment classification (APC) relative weights due to the artificial payment caps that are no longer related to hospital costs. Each APC has a relative weight based on the geometric mean cost for the procedures in the group relative to the geometric mean cost for a mid-level E/M clinic visit.
Additional Hospital Outpatient Services at Risk for Site-Neutral Cuts

THE ISSUE

Congress is considering a proposal to cap total payment for certain hospital outpatient department (HOPD) services at the physician rate. The Medicare Payment Advisory Commission (MedPAC) estimates that this would cut hospital outpatient payments by 2.6 percent, or $1.1 billion, in one year. This proposal reflects MedPAC discussions about expanding its “site-neutral” payment recommendation for hospital evaluation and management (E/M) services to other HOPD services. The services in these 66 ambulatory payment classifications (APCs) are routine outpatient services that are integral to hospitals’ service mission. However, MedPAC identified them as candidates for site-neutral cuts because a MedPAC staff analysis showed that they met several criteria, including being frequently performed in physician offices, infrequently provided with an emergency department visit and having minimal patient severity differences across settings.

Under the policy being considered, a hospital would be paid a residual amount calculated as the difference between the payment rate the physician would receive under the Medicare physician fee schedule (PFS) for a service furnished in his or her private office and the PFS rate paid for the service furnished in an HOPD. The policy would result in steep cuts. For instance, using data reflecting 2013 APC packaging policies, the hospital’s payment for a level II echocardiogram without contrast (APC 0269) would drop from $387.13, the average amount paid in 2013 under the outpatient prospective payment system (OPPS), to $127.29 – a 67 percent reduction.

At its January 2014 meeting, despite the AHA’s urging, MedPAC voted to formally recommend this policy without considering the several sweeping changes made in the calendar year (CY) 2014 hospital OPPS final rule. These changes, and subsequent changes proposed by the Centers for Medicare & Medicaid Services (CMS) for CY 2015, will have a substantial impact on MedPAC’s site-neutral payment policy and its associated savings estimate. In particular, these OPPS rules include new policies that significantly increase the amount of packaging in all APCs and will likely affect the impact of the estimates for the 66 APCs site-neutral payment recommendation.

In general, as CMS carries out its intentions, year after year, to shift the OPPS more definitively away from a per-service fee schedule to a prospective payment system with larger payment bundles, the package of services paid under the OPPS will become less comparable to those paid under the PFS. As a result, implementing site-neutral payment policies will more likely result in unfair and inaccurate payments. Further, larger payment bundles provide incentives to improve efficiency and better manage resources. Site-neutral payment policies will hamper this innovation. In addition, the MedPAC vote occurred amid continued stakeholder and commissioner concerns that the steep payment cuts could have unintended consequences for patient access to care and hospitals’ ability to continue to provide emergency standby services.

AHA POSITION

The AHA strongly opposes legislative proposals to reduce Medicare payment rates for these 66 APCs to a residual amount of the PFS payment rate or to the rate paid in Ambulatory Surgery Centers (ASCs).

Additionally, MedPAC and Congress are considering an alternate site-neutral proposal that would base payments for HOPD services on the rates Medicare pays for services in ASCs. The impact of this alternate approach also would be significant; currently, Medicare pays for covered surgical services in ASCs at approximately 60 percent of the rate that it pays for similar services in the HOPD. MedPAC is considering a policy that would reduce HOPD payment for 12 APCs that are commonly performed in ASCs to the ASC level. MedPAC estimates that this policy would reduce hospital outpatient payment by $590 million per year or a 1.7 percent decrease.

Continued on reverse
Unlike physician offices and ASCs, hospitals play a unique and critical role in the communities they serve by providing a wide range of acute-care and diagnostic services, supporting public health needs, and offering many other services that promote the health and well-being of the community. In addition, hospitals provide emergency standby services such as:

■ 24/7 Access to Care: Providing health care services, including specialized resources, 24 hours a day, seven days a week (24/7), 365 days a year.

■ The Safety Net: Caring for all patients who seek emergency care regardless of ability to pay.

■ Disaster Readiness and Response: Ensuring that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions.

These critical roles, while often taken for granted, represent essential components of our nation’s health and public safety infrastructure. It is critical that Congress consider these unique roles of hospitals and refrain from imposing site-neutral payment cuts on HOPD services. For example, hospitals provided $46 billion of uncompensated care in 2012. By contrast, many physicians and ASCs do not serve Medicaid and charity care patients.

In addition, despite its importance, hospitals’ standby role is not explicitly funded. There is no payment for a hospital and its staff to be at the ready until a patient with an emergency need arrives. Without such explicit funding, the standby role is built into the cost structure of full-service hospitals and supported by revenue from direct patient care – a situation that does not exist for physician offices, ASCs or any other type of provider.

Hospitals today face challenges in maintaining this role, such as staffing and space constraints, greater expectations for preparedness, the erosion of financial support from government payers, and the loss of patients to other settings that do not have the added costs of fulfilling the standby role.

WHY?

■ Hospitals already lose money treating Medicare patients in HOPDs. According to MedPAC’s June 2014 Data Book, Medicare margins are negative 11.2 percent for outpatient services. Additional cuts to HOPDs threaten beneficiary access to these services.

■ HOPDs provide services that are not otherwise available in the community to vulnerable patient populations. The reduction in outpatient Medicare revenue to hospitals will threaten access to critical hospital-based services, such as care for low-income patients and services for patients with multiple chronic conditions.

■ HOPDs serve a higher percentage of disabled patients than physician offices. HOPDs also serve a higher percentage of dual-eligible patients and non-white patients than physician offices and ASCs.

■ Patients who are too sick for physician offices or too medically complex for ASCs are treated in the HOPD. Physicians refer more complex patients to HOPDs for safety reasons, because hospitals are better equipped to handle complications and emergencies. As such, compared to freestanding physician offices and ASCs, HOPDs treat patients with a higher average risk for complications.

■ HOPDs have more comprehensive licensing, accreditation and regulatory requirements than do free-standing physician offices and ASCs.

■ Payment should reflect HOPD costs, not physician or ASC payments. HOPD payment rates are based on hospital cost report and claims data. In contrast, the physician payment schedule (and specifically the practice expense component) is based on voluntary responses to physician survey data and has been held flat for years due to the cost of various physician payment “fixes.” ASCs do not even report costs.

■ The Medicare payment systems for physicians, ASCs and HOPDs are complex and fundamentally different, with many moving parts. Practically speaking, this makes the application of MedPAC’s site-neutral policy unstable, with any number of small technical and methodological decisions changing the outcome significantly. Basing hospital payments on such a volatile methodology could have unintended consequences.
Some policymakers are advocating for a significant reduction in Medicare graduate medical education (GME) payments to teaching hospitals. The president’s fiscal year (FY) 2015 budget 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 $14.6 billion over 10 years. The Simpson-Bowles deficit 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.

An Institute of Medicine (IOM) committee in July recommended replacing Medicare’s separate funds for indirect and direct GME with one direct payment to program sponsors based on a geographically adjusted national per-resident amount. The proposal also uncouples Medicare payments for GME from care for seniors at a time when 10,000 Americans a day become eligible for Medicare. The AHA was especially disappointed that the report proposes phasing out the current Medicare GME funding provided to hospitals and offering it to other entities that do not treat Medicare patients. The proposed medical education changes would weaken the critical, diverse training students receive in hospitals, where they learn to care for America’s seniors, many of whom have multiple chronic illnesses. Further, the recommendations do not adequately address the current limits on the number of Medicare-funded residency training slots when our nation is already facing a critical shortage of physicians. The report also ignores how hospitals are already addressing the changing health care landscape by providing training in outpatient settings such as community clinics; giving a common infrastructure to support all residents; and recognizing that some specialties, like neurosurgery, require training only in an inpatient environment.

**WHY?**

- **Cuts to GME funding would jeopardize the ability of teaching hospitals to train the next generation of physicians.** Reductions to GME funding would have significant impact, including forcing teaching hospitals to eliminate staff, close training programs and eliminate services operating at a loss. The AHA opposes any cuts to GME funding because they would result in fewer physicians being trained and reduce access to care across the country.

- **Reductions in the IME adjustment would directly threaten the financial stability of teaching hospitals.** In February 2011, the Association of American Medical Colleges estimated the impact of federal IME cuts and found that a 60 percent reduction in IME payments could mean a loss of 72,600 jobs, $653 million in state and local tax revenue, and $10.9 billion to the U.S. economy.

- **The nation is already facing a critical shortage of physicians, and cuts to IME/direct GME would further exacerbate the problem.** Experts indicate that the nation could face a shortage of as many as 130,000 doctors by 2025. The expansion of health care coverage would increase overall demand for physicians and would increase the projected physician shortfall by up to 31,000 physicians. Physician shortages will hamper national efforts to improve access to care and may result in longer wait times for patients.

- **Limits on the number of Medicare-funded residency training slots constrain the ability of hospitals to train new physicians.** 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. We urge Congress to eliminate the 18-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 percent increase in residency slots) as included in the Resident Physician Shortage Reduction Act of 2013 (S. 577), introduced by Sens. Bill Nelson (D-FL), Harry Reid (D-NV) and Charles Schumer (D-NY).
Continued

KEY FACTS

Teaching hospitals serve a unique and critical role in the nation’s health care system. They not only train future health care professionals but also conduct medical research and serve a distinct and vital role in delivering patient care. They are centers of research and innovation, helping to develop new treatments and cures, and provide highly-specialized services such as burn care. Yet Medicare does not cover the total cost of care provided to Medicare beneficiaries. In its March 2013 report, the Medicare Payment Advisory Commission indicated that the overall Medicare margin was negative 2.4 percent for major teaching hospitals and negative 5.4 percent for other teaching hospitals.

The Medicare program has long recognized its responsibility for funding its share of the direct and indirect costs for training health professionals.

IME payments are explicitly made to compensate for the higher costs associated with teaching hospitals, such as residents’ “learning by doing,” greater use of emerging technology and greater patient severity. The IME payment adjustment is a percentage add-on to the hospital’s inpatient prospective payment system, and it varies based on the intensity of the hospital’s teaching programs as measured by the ratio of residents to hospital beds. The number of residents included in the calculation of the resident-to-bed ratio is capped at 1996 levels.

Direct GME payments help fund the teaching costs of residency programs, such as resident salaries and benefits, faculty salaries and benefits, and administrative overhead expenses. These payments are based on a hospital-specific, per-resident cost in 1984, updated annually for inflation. The per-resident payment amount varies by the residents’ specialties. The resident count for most hospitals also is capped at their 1996 levels.

According to CMS, there are 1,038 teaching hospitals. Teaching hospitals directly employ 2.7 million people and are often among the largest employers in their communities. They are major economic engines, generating business, employment and tax revenue.
Facts about The Medicare Audit Improvement Act of 2013 (H.R. 1250/S. 1012)

H.R. 1250/S. 1012 Does Not Diminish Medicare Fraud Fighting

- If a hospital engages in fraud, that organization can – and should – be held accountable under the False Claims Act.
- Recovery Audit Contractors’ (RACs) primary task is assessing payment accuracy – not addressing fraud. If a RAC identifies fraud, it must refer that case to a Medicare fraud-fighting entity.
- H.R. 1250/S. 1012 does not place any limits on the ability of any entity charged with fighting Medicare fraud to do so. Medicare fraud fighters are Zone Program Integrity Contractors, the Department of Health and Human Services (HHS) Office of Inspector General and the Department of Justice.

Hospitals Work Hard to Accurately Bill Medicare the First Time

- Hospitals take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries.
- Hospitals make large investments in personnel, software and compliance program checks and balances to avoid costly and time-consuming inaccuracies.
- Hospitals want to bill, and be paid, accurately the first time.

  RAC Fact:
  Nearly 60% of the hospital medical records reviewed by RACs are found to have no overpayment error.¹

Hospitals Need a Level Playing Field with RAC Bounty Hunters

- RACs are not impartial judges of Medicare payments. Rather, RACs prosper financially from commissions on each rejected claim.
- A single auditor can produce dozens of denials per day, while hospitals must appeal every incorrect denial through a two-or-more year, one-claim-at-a-time appeal.
- RAC auditors much later second guess the medical decisions made by physicians who examined and treated a Medicare beneficiary in a hospital.
- RACs audit services that are up to three years old, but hospitals can only rebill RAC decisions on services from the prior 12 months.

  RAC Fact:
  RAC auditors are typically nurses and therapists, who are paid to second guess the medical expertise of the physicians who treated Medicare beneficiaries.

RAC Appeals Are Adding Costs to an Overloaded System

- Nearly three-fourths of all appealed claims are still sitting in the appeals process.¹
- Each appeal typically requires two or more years for a final decision.
- The extreme backlog of appeals has resulted in a suspension of assignment of at least two years for appeals to the Administrative Law Judge (ALJ); wait time of at least an additional six months occur before a judge hears an appeal after assignment.

  RAC Fact:
  49% of hospital denials are appealed¹ and 72% of appeals brought before an ALJ are overturned in favor of the hospital.²

H.R. 1250/S. 1012 Would Fix Many Problems with the RAC Program

- H.R. 1250/S. 1012 would correct persistent operational problems by the RACs.
- H.R. 1250/S. 1012 would correct Centers for Medicare & Medicaid Services (CMS) policies that provide hospitals with less than full payment for reasonable and necessary care.
- H.R. 1250/S. 1012 would establish manageable limits on record requests and ease the heavy administrative burden for hospitals.
- H.R. 1250/S. 1012 would require transparent reporting of RAC audit and appeals.

¹AHA RACTrac survey of 2,400+ hospitals. Quarter 4, 2013 data.
Facts about Recovery Audit Contractors (RACs)

RACs are Bounty Hunters
RACs are not impartial judges of payment accuracy because they receive a commission on every claim they deny.

Fixing the RAC Program Does NOT Reduce Fraud-Fighting Efforts
The primary task of RACs is to assess the accuracy of Medicare payments.

Medicare fraud fighters are Zone Program Integrity Contractors, the Department of Health and Human Services (HHS) Office of Inspector General and the Department of Justice. If a RAC identifies fraud, it must refer that case to a Medicare fraud-fighting agency.

If a hospital engages in fraud, that organization can – and should – be held accountable under the False Claims Act.

RACs are Inaccurate
Despite being charged with ensuring the accuracy of Medicare payments, and despite a supposed expertise in identifying inaccuracies, RACs have a hard time finding legitimate errors in hospital claims.

Only two-fifths of the hospital charts audited by RACs are found to contain a payment error. Even the Centers for Medicare & Medicaid Services (CMS) has recognized that RACs find no error in a majority of the records they audit.

The accuracy of RAC findings also is called into question by their high overturn rate: 72 percent of RAC denials that are appealed to an Administrative Law Judge are overturned in favor of the hospital, according to the OIG.

CMS is Not Paying for All Medically Necessary Care
CMS is violating its legal requirement to pay hospitals for all care that is reasonable and necessary. If a Medicare auditor finds that hospital care should have been provided on an outpatient rather than an inpatient basis, Medicare should provide full outpatient payment for the services provided.

Many inpatient claims denied by RACs are disqualified from full payment through the rebilling process because of the date of service. CMS allows hospitals to rebill only for services from the prior year, even though RACs can audit claims from the prior three years. RACs often deny services that are more than one year old, and therefore hospitals are disqualified from full outpatient payment through rebilling. This leaves hospitals with only one remedy to seek full payment for the denial – a Medicare appeal.

In addition, CMS has exempted some services from outpatient payment following a RAC denial of an inpatient claim. This often means that, even if a hospital can meet the timely filing requirement, a portion of full outpatient payment will be withheld by CMS.

Continued
The Medicare Appeals Process is Broken

Hospitals face a highly uneven playing field when they appeal an erroneous RAC denial. To recapture full payment for reasonable and necessary care, hospitals must separately appeal each RAC denial through a two or more year appeals process.

Nationwide, hospitals report appealing almost half of all RAC denials. 72 percent of denials appealed to ALJ have been overturned in favor of the hospital. More than two out of every three appealed claims are still sitting in the appeals process.¹

The extreme backlog of appeals has resulted in the suspension of assignment of appeals to an ALJ for at least two years. Since payment for claims denied by a RAC are recouped before the ALJ level of appeal, a significant amount of hospital funds may be held captive for years while the hospital waits for an appeals hearing.

CMS recently exacerbated appeals delays when it inappropriately allowed RACs to double the volume of audits. The appeals process is not only lengthy, but extremely costly. Many hospitals do not have the resources to pursue Medicare appeals.

The RAC Program Needs Better Oversight & Management

After three years, CMS has not corrected chronic operational problems within the RAC program. Problems include overdue audit decisions; very late issuance of key correspondence hospitals need to manage Medicare payments and appeals; and a high overturn rate for appealed RAC denials.

Despite these persistent problems, CMS in spring 2012 doubled the volume of claims that RACs may audit. The agency also allows RACs to continue to deny claims frequently overturned on appeal.

RACs are Second Guessing Physicians

Medicare rules grant physicians the authority to decide whether a patient should be admitted to a hospital. In these rules, CMS recognizes that deciding whether to admit a patient to a hospital is a “complex medical judgment” that requires the professional expertise of doctors.

RACs hire auditors – typically nurses and therapists – to subjectively evaluate paper charts up to three years after the patient was treated. RACs are only required to hire one physician, which leaves most second guessing to non-physician auditors.

¹AHA RACTrac survey of 2,400+ hospitals. Quarter 4, 2013 data.
How a Well-Intentioned Federal Program Has Become a Drain on Hospitals
The national Recovery Audit Contractor (RAC) program began in 2010 with the goal of ensuring accurate payments to Medicare providers. However, 5 years later, the program requires fundamental reform.

Unlawful policy prevents full payment for needed patient care.

- Many denials are for inpatient care (Part A) that was medically necessary, but RACs contend the care could have been provided in the hospital outpatient (Part B) setting.
- Medicare rules prohibit hospitals from rebilling these services for payment under Part B if they are older than 1 year, while RACs can audit medical records up to 3 years old.

This disparity costs hospitals millions and violates CMS’s statutory requirement to pay for all reasonable and necessary care.

RACs are bounty hunters paid a contingency fee based on the money clawed back from denied claims.

For each Medicare claim they deny, RACs receive a commission of 9.0 - 12.5%.

Due to this incentive structure, RACs frequently target high-dollar inpatient claims.

RACs often make errors and inflict avoidable legal and administrative costs on hospitals.

- RACs find no overpayment error with 58% of audited claims.
- RAC-denied claims: 42%

49% of denied claims are appealed.

68% of hospitals spend $40,000+.

50% of hospitals spend $100,000+.

34% of hospitals spend $200,000+.

12% of hospitals spend $400,000+.

72% of appealed hospital Medicare Part A denials are fully overturned at the third level of appeal.

RACs’ errors and inefficiencies force hospitals to redirect resources that could have otherwise been used for patient care.

Assignment of most new requests for an Administrative Law Judge hearing will be temporarily suspended . . . for at least 24 months. — Office of Medicare Hearings and Appeals, December 2013

Your support of H.R. 1250/S. 1012 will help fix the flawed RAC system.
FACTSHEET

‘Two-Midnight’ Admission and Medical Review Criteria Policy

THE ISSUE

On Aug. 2, 2013, the Centers for Medicare & Medicaid Services (CMS) finalized its “two-midnight” policy whereby the agency will generally consider hospital admissions spanning two midnights as appropriate for payment under the inpatient prospective payment system (PPS). In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. The policy took effect Oct. 1, but enforcement has been partially delayed through March 31, 2015.

CMS has issued a limited number of guidance documents to assist hospitals in implementing this policy. These documents address only narrow aspects of the policy, lack clarity and raise new questions for hospitals. As of April 1, hospitals are still waiting for additional guidance and answers from CMS, which CMS announced would be forthcoming.

AHA POSITION

Support the Two Midnight Delay Act (H.R. 3698) and the Two-Midnight Coordination and Improvement Act (S. 2082), which would require CMS to implement a new payment methodology for short inpatient stays in fiscal year 2015. In addition, we support the Senate provision that would extend CMS’s partial enforcement delay through Oct. 1, 2015, or when the agency implements criteria defining short stays, whichever is first.

WHY?

• Hospitals need more time to come into compliance with the two-midnight policy. Even with the partial delay in enforcement through March 31, 2015, there has not been enough time for hospitals to adjust. While there are some positive aspects of the policy that should be retained, hospitals need more time to evaluate and change internal policies, update existing electronic medical records systems, alter work flow processes and provide extensive education to hospital staff to ensure compliance with the new policy.

• Many questions about the two-midnight policy remain unanswered. The Oct. 1, 2013, implementation date has passed, yet CMS has issued only minimal guidance – most of which lacks clarity and only raises new questions for hospitals. A further delay in enforcement is necessary to allow CMS to issue clear, detailed and precisely written guidance to hospitals and Medicare review contractors and to allow hospitals additional time to operationalize these provisions appropriately.

• CMS needs to engage stakeholders to find a workable solution for short-stay patients. Complex patient stays of less than two midnights often require the same amount of resources as stays lasting more than two midnights. CMS should continue discussions with all affected parties to develop workable solutions – including the possibility of a long-term payment alternative – to address the reasonable and necessary inpatient-level services currently provided by hospitals to Medicare beneficiaries that are not expected to span two midnights.

• Beneficiaries are unaware of these changes and their impact. CMS has not provided communication to beneficiaries on this policy, meaning that hospitals will be in the position of explaining a significant coverage limitation at a patient’s most vulnerable time.

Continued on reverse
KEY FACTS

CMS’s two-midnight policy was implemented partially in response to the growing number of Medicare beneficiaries who receive observation services for more than 48 hours. However, the decision to admit a patient as an inpatient is a complex medical judgment that involves the consideration of many factors, such as the patient’s medical history and medical needs, the types of facilities available to inpatients and outpatients, the hospital’s bylaws and admission policies, the relative appropriateness of treatment in each setting, patient risk of an adverse event, and other factors. Hospitals strive to base admission decisions on these clinical considerations; yet, the medical judgment of the treating physician is all too often second guessed by auditors, including Recovery Audit Contractors, months or even years after the fact. Hospitals risk loss of reimbursement, monetary damages and penalties from auditors when they admit patients for short, medically necessary, inpatient stays. On the other hand, they face criticism from patients and CMS over the perceived use of observation status as a substitute for inpatient admission.

CMS’s two-midnight policy includes the following key provisions:

- **Two-midnight benchmark**, which imposes a time-based standard for payment of inpatient admissions – an inpatient admission will generally be appropriate for payment under the inpatient PPS when the beneficiary is expected to remain in the hospital for more than two midnights.

- **Two-midnight presumption**, which instructs Medicare review contractors to presume that hospital claims with lengths of stays greater than two midnights after a physician order for admission are reasonable, necessary and generally appropriate for payment under the inpatient PPS.

- **Physician order and certification requirements**, which require that an order supported by medical information, including physician admission and progress notes, must be made by a physician (or other qualified practitioner, as provided in the regulations) and present in the medical record in order for the hospital to receive payment under the inpatient PPS.

- **Inpatient PPS offset**, whereby the agency provided a 0.2 percentage point cut to inpatient payments to offset the estimated $220 million in additional inpatient PPS expenditures it believes will be associated with the two-midnight policy.

CMS partially delayed enforcement of the two-midnight policy and will not conduct post-payment patient status reviews for claims with dates of admission from Oct. 1, 2013 through Sept. 30, 2014. Additionally, Congress, as part of The Protecting Access to Medicare Act of 2014 extended the partial enforcement delay through March 31, 2015. However, during that time period, CMS will move forward with prepayment “Probe and Educate” audits for inpatient admissions claims. The agency will allow Medicare Administrative Contractors (MACs) to assess hospital compliance with the two-midnight policy, focusing on the admission order requirements, certification requirements and two-midnight benchmark, and deny claims that they deem as out of compliance. MACs will be required to conduct educational outreach efforts to hospitals with denied claims, including individualized phone calls, answering questions and providing pertinent education and reference materials.

AHA-supported bills have been introduced to fix critical flaws in the two-midnight policy. Specifically, the Two Midnight Rule Delay Act (H.R. 3698) and Two-Midnight Coordination and Improvement Act (S. 2082) would require CMS to implement a new payment methodology for short inpatient stays in fiscal year 2015. In addition, S. 2082 would extend CMS’s partial enforcement delay until Oct. 1, 2015, or when the agency implements criteria defining short stays, whichever is first.
THE ISSUE

Beginning in fiscal year (FY) 2008, the Centers for Medicare & Medicaid Services (CMS) refined the method it uses to categorize patients for purposes of payment under the inpatient prospective payment system (PPS). The agency claimed that there would be improved documentation and coding for patient severity of illness as hospitals moved to the new system, which would result in higher payments. In response, Congress initially required CMS to make prospective cuts to hospital payments to account for these higher payments, as well as to make retrospective cuts, if necessary, to recoup overpayments from FYs 2008 and 2009. In the American Taxpayer Relief Act of 2012 (ATRA), Congress required CMS to recoup alleged overpayments made in FYs 2010-2013, an additional cut to hospitals of $11 billion. The law also clarified that the Secretary of Health and Human Services has the authority to make an additional prospective documentation and coding cut of 0.8 percent to remove what it claimed were increased FY 2010 payments from the system. Although this cut was proposed by CMS but subsequently withdrawn, some policymakers are interested in this additional cut as part of deficit reduction.

WHY?

- For America’s already financially strained hospitals, an additional reduction in Medicare payments could result in the loss of health services and programs that are essential for Medicare beneficiaries, as well as other patients.

- The Medicare program already pays less than the cost of providing care to Medicare beneficiaries. The Medicare Payment Advisory Commission (MedPAC) found that overall Medicare margins declined from negative 4.5 percent in 2010 to roughly negative 5.8 percent in 2011 and continue to fall well below the cost of caring for America’s seniors. MedPAC estimates that aggregate Medicare hospital margins in FY 2014 will be negative 6.0 percent. Additional cuts are not warranted.

- CMS’s estimate of the effect of documentation and coding and, therefore, the cuts the agency has already made, are overstated. CMS asserted that a total prospective cut of 5.4 percent was necessary. However, AHA’s analysis indicates that this prospective adjustment should have totaled 3.5 percent and that no further cuts were warranted related to case-mix change in 2010. This 1.9 percent difference will inappropriately reduce hospital payments and amounts to a cut of $22.6 billion over the next 10 years. Now Congress has added another cut of $11 billion, bringing the total value of excess cuts to hospitals to nearly $34 billion.

- It is inappropriate to consider even more cuts to hospitals based on a flawed methodology. CMS continues to compare hospital documentation and coding in FY 2010 to documentation and coding under a diagnosis-related group (DRG) system that was discarded in FY 2007. The inpatient PPS changed substantially from FY 2007 to FY 2010. For example, the 2010 system utilized cost-based (rather than charge-based) data, allowed up to 25 (rather than nine) diagnoses codes per claim, and used a completely reformed list to document patient complications and comorbidities. Yet, CMS continues to believe that the case-mix index should be the same when using the new versus old system to measure patient severity levels in 2010. It is time to fully embrace the new improved system and to stop comparing it to the prior, obsolete system.

AHA POSITION

Reject any further documentation and coding cuts to hospital payments.

Continued on reverse
Medicare pays hospitals under a PPS, which allows providers to reasonably estimate payments in advance. A PPS should be simple, transparent and predictable over time. Congress already has required CMS to make one set of prospective cuts and retrospective recoupments. Instituting further cuts flies in the face of the purpose of a PPS – to give providers the ability to reasonably estimate payments in advance to inform their budgeting, marketing, staffing and other key management decisions.

KEY FACTS

Under the inpatient PPS, each patient’s case is categorized into a DRG that has a set payment rate. Beginning in FY 2008, CMS began a transition to a more refined DRG system, known as Medicare Severity-DRGs (MS-DRGs), because the prior DRG system was found to inadequately account for differences in patient acuity. However, the agency claimed that changes in hospital documentation and coding practices in response to the new system would lead to increases in case mix – and associated payments – that did not reflect real changes in patient acuity. Therefore, it planned to adjust payments to remove what it estimated to be the documentation and coding effect.

In response, Congress required CMS to apply an adjustment of negative 0.6 percent in FY 2008 and negative 0.9 percent in FY 2009 to inpatient payments. They also specified that, to the extent that these two adjustments were over- or under-stated relative to the actual amount of documentation and coding-related change, CMS should make additional prospective cuts, as well as retrospective cuts to recoup the remaining overpayments. The agency implemented a prospective cut of 2.0 percent in FY 2012 and 1.9 percent in FY 2013, for a total prospective cut of 5.4 percent. In addition, it implemented a retrospective cut of 2.9 percent in both FYs 2011 and 2012, for a total recoupment of 5.8 percent. CMS’s recoupment of overpayments in FYs 2008 and 2009 was completed as of the end of FY 2013.

The ATRA requires the secretary to make a temporary adjustment to the standardized amount in FYs 2014, 2015, 2016 and 2017 to recoup overpayments that occurred in FYs 2008 through 2013 during the transition to MS-DRGs. These overpayments, estimated to be $11 billion, allegedly occurred because the prospective adjustments made in each year did not fully offset the additional payments made because of documentation and coding change. The AHA does not agree with this analysis.

In addition, for FY 2013, CMS proposed a new cut of 0.8 percent to permanently remove what it claims were increased FY 2010 payments from the system. An AHA analysis found that much smaller documentation and coding adjustments were necessary than what CMS implemented. These analyses indicate that much of the change CMS found is actually the continuation of historical increases in patient severity, not the effect of documentation and coding changes due to the implementation of the MS-DRGs. Specifically, AHA data indicate that CMS’s prospective adjustment should have totaled 3.5 percent, not 5.4 percent. CMS’s current cuts are excessive and the additional cuts added by ATRA are even more so. It is inappropriate for the agency to continue to compare hospital documentation and coding in FY 2010 and beyond to documentation and coding under a DRG system that was discarded in FY 2007. CMS withdrew its proposal for the new 0.8 percent cut in its FY 2013 final rule. CMS agreed with AHA’s position that a smaller cut would be appropriate in its FY 2014 proposed and final rules. CMS has not implemented this cut at this time.
Medicaid Provider Assessments

THE ISSUE

The Medicaid provider assessments program has allowed state governments to expand coverage, fill budget gaps and maintain patient access to health services to avoid additional provider payment cuts by helping states finance their portion of the joint federal/state program. Some policymakers have called for restricting states’ ability to use assessments as a financing tool. The president’s fiscal year (FY) 2013 budget proposed to phase down, but not eliminate, Medicaid provider assessments beginning in 2015. The administration estimated this would save $21.8 billion over 10 years. The House approved its FY 2013 budget reconciliation package with cuts to Medicaid provider assessments of $11.2 billion over 10 years. The Simpson-Bowles deficit commission also recommended restricting, and eventually eliminating, states’ ability to use assessments on health care providers to finance a portion of their Medicaid spending. This proposal to eventually eliminate provider assessments would result in estimated reductions of $44 billion in the Medicaid program by 2020.

Following a Congressional request, the Government Accountability Office in July 2014 released a report on states’ use of various sources of funds to finance the nonfederal share of Medicaid, such as provider assessments. This report found an increased reliance on providers and local governments and the need for more transparency around state financing methods and payments to providers. In addition, the Centers for Medicare & Medicaid Services recently issued guidance on permissible health related taxes in response to a May 2014 Department of Health and Human Services Office of Inspector General report on the taxing of Medicaid managed care plans.

AHA POSITION

Reject options that restrict states’ ability to partially fund Medicaid programs using provider assessments.

WHY?

- 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.
- Further cuts to hospital funding would put enormous pressure on already stretched state budgets and could jeopardize this critical health care safety-net program.
- Hospitals already experience payment shortfalls when treating Medicaid patients. Medicaid, on average, covers only 89 cents of every dollar spent treating Medicaid patients. Changes to the provider assessment program would further exacerbate this problem.
- Currently, 67 million low-income Americans rely on the Medicaid program to provide access to health care. With implementation of the Affordable Care Act (ACA), as many as 13 million more people may be enrolled in Medicaid beginning in 2014 (based on April 2014 Congressional Budget Office estimates). Any reduction or elimination of Medicaid provider assessments would be on top of Medicaid cuts made at the state level.

Continued on reverse
Over its 46-year history, Medicaid has become the nation’s health care safety net, serving as a buffer to the perils of an uncertain economy by providing access to health services for those who cannot afford private insurance. Medicaid is the safety net for millions of Americans, and its coverage role is expanding under the ACA.

Nearly all states employ some form of provider assessments – on hospitals, intermediate care facilities, nursing homes, managed care organizations or pharmaceuticals – as a means to obtain funds for their Medicaid programs.

A provider assessment, which also may be referred to as a fee or tax, is a mandatory payment imposed on providers by a state. Under federal law, these assessments cannot exceed 25 percent of the state share of Medicaid expenditures. Such an assessment must be: “broad based” (must cover at least all non-federal, non-public providers in a class – not just those who receive Medicaid payments); applied uniformly to all providers in a class; and without a “hold harmless” provision that would guarantee a provider an offset for any portion of the cost of the assessment.

According to the Kaiser Family Foundation, Medicaid covers:
- 1 in 3 children
- 1 in 3 births
- 8 million people with disabilities
- Nearly 9 million low-income Medicare beneficiaries
- 1 in 4 poor non-elderly adults.

Medicaid also is the major payer for long-term care services for low- and middle-income elderly. Medicaid pays for seven out of 10 people living in nursing homes. More than a quarter of all mental health funding is from Medicaid. And according to the Kaiser Family Foundation, during the recession from 2007 to 2009, 6 million people were covered by Medicaid who would have otherwise gone without health care coverage.

The provider assessment program is a critical component to funding Medicaid programs across the country. The program deserves a thoughtful, deliberate examination to design reforms that ensures the nation meets its obligation to care for the neediest of our society.

**KEY FACTS**

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The provider assessment program is a critical component to funding Medicaid programs across the country. The program deserves a thoughtful, deliberate examination to design reforms that ensures the nation meets its obligation to care for the neediest of our society.
Factsheet

Assistance to Low-income Medicare Beneficiaries (Bad Debt)

The Medicare program requires its beneficiaries to pay a portion of the cost of their care, for example, through the inpatient hospital deductible of more than $1,100 and through the outpatient hospital coinsurance of 20 percent. Many low-income beneficiaries cannot pay these amounts to the hospital, resulting in unpaid debt (sometimes referred to as “bad debt”). Historically, the Medicare program has reimbursed hospitals for a portion of the debt incurred by Medicare beneficiaries, particularly those with low incomes. The Middle Class Tax Relief and Job Creation Act of 2012 reduced these payments for prospective payment system (PPS) hospitals from 70 percent to 65 percent beginning in fiscal year (FY) 2013, and for critical access hospitals (CAHs) from 100 percent to 65 percent, phased-in over three years beginning in FY 2013. Thus, for CAHs, Medicare will pay 88 percent of allowable bad debt in FY 2013, 76 percent in FY 2014, and 65 percent in 2015 and beyond.

AHA Position

Reject further cuts to hospital payments for assistance in covering the debts of low-income Medicare beneficiaries.

Why?

- Reducing or eliminating this reimbursement disproportionately affects hospitals that treat high numbers of low-income Medicare beneficiaries – safety-net hospitals and rural hospitals:
  - It leaves safety-net hospitals with less ability to serve low-income Medicare beneficiaries, who may not be able to afford cost-sharing requirements.
  - It puts rural hospitals and the patients they serve under severe stress, as their small size leaves them with more limited cash flow and less of an ability to absorb such losses. In addition, rural hospitals have Medicare bad debt levels that are 50 percent higher than urban hospitals, on average.
- Medicaid frequently underpays beneficiaries’ Medicare cost-sharing obligations, leading to high levels of dual-eligible beneficiary debt. Dually-eligible beneficiaries account for roughly 20 percent of Medicare beneficiaries, but about 59 percent of hospitals’ Medicare bad debt.
- The Medicare program already pays less than the cost of providing care to Medicare beneficiaries. Reducing 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 inappropriate.
- Under Medicare’s statutory reasonable cost principles, costs of care that are attributable to Medicare beneficiaries cannot be shifted to non-Medicare patients, and vice versa. Thus, when hospitals are unable to collect cost-sharing payments owed by Medicare beneficiaries, they record these payments as bad debt and are reimbursed a portion of that Medicare debt directly from the Centers for Medicare & Medicaid Services (CMS).
- Medicare reimburses PPS hospitals for 65 percent of Medicare beneficiary debts. Historically, Medicare reimbursed hospitals for 100 percent of Medicare beneficiary debt; however, the Balanced Budget Act of 1997 reduced that to 75 percent in 1998, 60 percent in 1999, and 55 percent in 2000 and beyond. In the Benefits Improvement and Protections Act of 2000, Congress increased reimbursement to 70 percent when the negative effects of cutting payments for the most vulnerable and poor Medicare beneficiaries became evident. The Middle Class Tax Relief and Job Creation Act of 2012 reduced it to 65 percent for PPS hospitals in 2013 and beyond.

Continued on reverse
**KEY FACTS**

- **Beneficiaries’ out-of-pocket expenses for Medicare can be significant.** In 2013, the Part A hospital deductible is $1,216 per benefit period. The Part B deductible is $147 per year and the Part B coinsurance is 20 percent of the Medicare-approved payment amount. In addition, there is a Part B premium of about $105 per month, which varies depending on the beneficiary’s income. Although this premium cannot turn into bad debt, it still represents an out-of-pocket expense that could contribute to seniors’ inability to pay their other out-of-pocket expenses – deductibles and coinsurance.

- **About 20 percent of Medicare beneficiaries are dual eligibles** – low-income seniors and younger persons with disabilities who are enrolled in both the Medicare and Medicaid programs. To qualify as a dual eligible, a beneficiary’s income is generally limited to less than the federal poverty level (FPL) – $11,670 for a single person in FY 2013. These Medicare beneficiaries receive coverage under Medicaid, as well as Medicaid’s assistance in paying Medicare premiums and cost-sharing. Cost-sharing varies by state; however, Medicaid typically pays much less than the full deductible and coinsurance due. The unpaid amount is classified as Medicare bad debt. Beneficiaries with incomes above the dual-eligible qualification level but below 120 percent of the FPL also may qualify for Medicaid assistance in paying Medicare premiums and cost-sharing. For these beneficiaries as well, Medicaid typically pays much less than the full deductible and coinsurance due, and the unpaid amount is classified as bad debt.

- **Inner-city urban communities have large numbers and high proportions of Medicaid recipients and uninsured residents, and are highly likely to have large numbers and high proportions of low-income Medicare beneficiaries.**

- **Hospitals in the highest quartile of disproportionate share hospital (DSH) patient percentages have Medicare bad debt reimbursement as a percentage of their Medicare revenue that is more than two times higher than hospitals in the lowest quartile of DSH patient percentages, on average.**

- **About half of Medicare beneficiaries have incomes between 100 and 300 percent of the FPL, and cost sharing can represent a substantial portion of their income – they often cannot afford it.**

- **Below is an example of the cost sharing that would be incurred by a Medicare beneficiary with one hospital stay and associated physician visits in 2013 (in addition to this cost sharing, the beneficiary will have paid approximately $1,260 in Part B premiums for the year).**

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicare-approved Payment</th>
<th>Beneficiary Cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital Stay</td>
<td>$16,653</td>
<td>$1,216</td>
</tr>
<tr>
<td>Physician</td>
<td>$10,514</td>
<td>$2,250</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$27,167</strong></td>
<td><strong>$3,466</strong></td>
</tr>
</tbody>
</table>

CMS has set forth stringent criteria that must be met in order for unpaid Medicare deductibles and coinsurance to be reimbursed. For example, CMS requires that, to obtain reimbursement to cover the debts of Medicare beneficiaries, the hospital ensure that reasonable collection efforts were made and the debt was actually uncollectible. Hospitals must meet specific and detailed criteria to receive reimbursement.

**A typical example of what a hospital must do in order to meet the criteria:**

1. Upon admission and at discharge, the hospital lets the patient know that he/she has a deductible and copayment and that he/she will be billed when Medicare pays the hospital;
2. The patient receives an explanation of benefits from Medicare, which informs him/her of his/her liability;
3. When Medicare pays the hospital, the hospital sends a bill to the patient;
4. After 30 days with no payment, the hospital sends another bill to the patient;
5. After another 30 days with no payment, the hospital sends another bill to the patient;
6. The hospital follows up with a personal phone call to the patient;
7. After another 30 days with no payment, the hospital sends another bill to the patient;
8. The hospital follows up with another personal phone call and a collection letter to the patient;
9. After another 30 days, the hospital sends the bill to a collection agency;
10. After 90 days, the collection agency returns the bill to the hospital as uncollectible;
11. At this point, the hospital has satisfied Medicare’s criteria and may claim reimbursement for the debt.
The 340B Drug Pricing Program

THE ISSUE

Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in the Medicaid drug rebate program to sell outpatient drugs at discounted prices to taxpayer-supported health care facilities that care for uninsured and low-income people. The program enables eligible entities, including hospitals and community health centers, to stretch scarce federal resources to reduce the price of pharmaceuticals for patients, expand services offered to patients and provide services to more patients. In addition, the program generates savings for the federal and state governments.

In 1990, Congress established the Medicaid drug rebate program, which requires drug manufacturers to enter into and have in effect a rebate agreement with the Secretary of Health and Human Services (HHS). The rebate agreement requires pharmaceutical manufacturers to supply their products to state Medicaid programs at the manufacturer’s “best price” – that is, the lowest price offered to other purchasers. On the heels of the Medicaid drug rebate law, Congress extended similar savings from high drug costs to safety-net providers through the establishment of the 340B Drug Pricing Program.

Section 340B covered entities include community health centers, children's hospitals, hemophilia treatment centers, critical access hospitals (CAHs), sole community hospitals (SCHs), rural referral centers (RRCs), and public and nonprofit disproportionate share hospitals (DSH) that serve low-income and indigent populations.

According to the Health Resources and Services Administration (HRSA), the federal agency responsible for administering the 340B program, enrolled hospitals and other covered entities can achieve average savings of 25 to 50 percent in pharmaceutical purchases. Despite recent HRSA efforts to exert more 340B program oversight and the program’s proven record of decreasing government spending and expanding patient access, some in Congress may attempt to scale it back or significantly reduce the benefits eligible hospitals and their patients receive from the program.

AHA POSITION

The AHA opposes efforts to scale back or significantly reduce the benefits of the 340B program.

The AHA believes the 340B program is essential to helping safety-net providers stretch limited resources to better serve their communities.

The AHA supports program integrity efforts to ensure this vital program remains available to safety-net providers and encourages HRSA to develop a process to help financially distressed providers meet new program integrity provisions.

The AHA supports extending the 340B discounts to the purchases of drugs used during inpatient hospital stays, expanding the program to certain rural hospitals, and eliminating the orphan drug exclusion for certain 340B hospitals.
WHY?

- **Many 340B-eligible hospitals are the safety net for their communities.** The program allows these hospitals to further stretch their limited resources and provide additional benefits and services to their communities.
- **Better program oversight and clear program guidance will help 340B hospitals.** But program policy changes should occur with stakeholder consultation and allow for reasonable transition periods.
- **Expansion of the program would be a “win-win” for taxpayers, as well as for hospitals.** Expanding the 340B program would generate savings for the Medicaid program by requiring hospitals to rebate Medicaid a percentage of their savings on inpatient drugs administered to Medicaid patients. This change would also reduce Medicare costs, as CAHs are paid 101 percent of their inpatient and outpatient costs by Medicare, and the 340B pricing mechanism would lower CAHs’ drug costs. According to the Congressional Budget Office, expanding the program to cover inpatient services would save the federal government upwards of $1.2 billion.

KEY FACTS

HRSA has implemented several 340B program integrity measures. These include audits of 340B entities and annual recertification. These measures stem from a 2011 Government Accountability Office (GAO) report that criticized HRSA’s oversight of the program. For example, based on preliminary findings from the hospital 340B audits, in February 2013 HRSA issued a 340B program notice intended to clarify program policy regarding the statutory prohibition against obtaining outpatient drugs through a group purchasing organization (GPO). Disproportionate share, children’s and free-standing cancer 340B hospitals are prohibited from using GPOs to make any outpatient drug purchases, but they may purchase all inpatient drugs through a GPO.

HRSA initially allowed covered entities only 60 days after the publication of the GPO policy notice to make certain their 340B inventory management practices complied with the GPO policy. Based on feedback from the AHA and its 340B member hospitals, HRSA extended the compliance deadline to six months to allow time for stakeholders to make the necessary changes.

HRSA in July 2013 finalized its regulation implementing the orphan drug exclusion for RRCs, CAHs and free-standing cancer hospitals. It allowed these hospitals to purchase orphan drugs, as long as these drugs are not used to treat the rare conditions or diseases for which they received orphan status, which limits the exclusion for these hospitals and provides them greater access to 340B discounted drugs. The AHA supports HRSA’s limitation on the orphan drug exclusion. In addition, the regulation included several AHA-supported modifications, such as allowing hospitals subject to the exclusion to establish an alternative compliance system and permitting free-standing cancer hospitals to opt out of using the 340B program to purchase orphan drugs and instead purchase the orphan drugs through a GPO.

In September 2013, the Pharmaceutical Research and Manufacturers of America (PhRMA) filed a lawsuit in federal district court to stop HRSA’s implementation of the orphan drug final rule, basing its challenge on the contention that HRSA lacks the authority to issue regulations. The AHA filed an amicus brief supportive of HRSA’s interpretation of the orphan drug exclusion. On May 23, 2014, the U.S. District Court for the District of Columbia ruled against HHS and HRSA in support of PhRMA’s claim that the agency does not have authority to impose its interpretation through rulemaking. HHS and HRSA subsequently issued their orphan drug policy on July 21 as “interpretive guidance.” On Aug. 27, the court, in its final judgment, stated that PhRMA’s efforts to block the interpretive guidance is outside the scope of this case and that PhRMA would have to file a new lawsuit to challenge the agencies subsequent actions. HRSA also plans to issue a comprehensive proposed regulation, known as the “Mega Rule” to address such issues as eligibility, patient definition and contract pharmacy.

In light of the court’s decision, HRSA’s release of the proposed rule may be delayed.

### 340B Hospital Eligibility

<table>
<thead>
<tr>
<th>340B Eligible Hospital</th>
<th>DSH%</th>
<th>GPO Prohibition</th>
<th>Orphan Drug Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disproportionate Share Hospital</td>
<td>&gt;11.75%</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Children’s Hospital</td>
<td>&gt;11.75%</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cancer Hospital</td>
<td>&gt;11.75%</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Critical Access Hospital</td>
<td>N/A</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Sole Community Hospital</td>
<td>≥8%</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Rural Referral Center</td>
<td>≥8%</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Source: Apexus and HRSA, 2013*
Rural and Small Hospitals

Because of their size, modest assets and financial reserves, and higher percentages of Medicare patients, small and rural hospitals disproportionately rely on government payments. Medicare payment systems often fail to recognize the unique circumstances of small or rural hospitals. Many rural hospitals are too large to qualify for critical access hospital (CAH) status, but too small to absorb the financial risk associated with prospective payment system (PPS) programs. With deficit reduction as a key goal in Washington, small and rural health care providers continue to be in jeopardy.

AHA POSITION

The AHA is focused on ensuring all hospitals have the resources they need to provide high-quality care and meet the needs of their communities. That means:

• Advocating for appropriate Medicare payments;
• Working to extend expiring Medicare provisions that help them maintain financial viability;
• Improving federal programs to account for special circumstances in rural communities; and
• Seeking adequate funding for annually appropriated rural health programs.

In addition, existing special rural payment programs – the CAH, sole community hospital (SCH), Medicare-dependent hospital (MDH), and rural referral center (RRC) programs – need to be reauthorized, updated and/or protected.

KEY PRIORITIES

Rural Legislation

The Protecting Access to Medicare Act of 2014 contained several provisions important to rural hospitals. The AHA continues to work to extend the law’s rural extender provisions, plus several others. Key rural hospital provisions are:

• MDH program (expires March 31, 2015);
• Low-volume hospital payment adjustment (expires March 31, 2015);
• Ambulance add-on payments (expires March 31, 2015); and
• Outpatient therapy caps exception process (expires March 31, 2015). (While the AHA supports extending the outpatient therapy exception process, we oppose the expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.)

The AHA will work with Congress to:

• Extend expiring provisions;
• Allow hospitals to claim the full cost of provider taxes as allowable costs;
• Ensure CAHs are paid at least 101 percent of costs by Medicare Advantage plans;
• Ensure that the Centers for Medicare & Medicaid Services (CMS) appropriately addresses the issue of direct supervision for outpatient therapeutic services for rural hospitals and CAHs;
• Ensure rural hospitals and CAHs have adequate reimbursement for certified registered nurse anesthetist and stand-by services;
• Exempt CAHs from the Independent Payment Advisory Board;
• Exempt CAHs from the cap on outpatient therapy services;
• Provide CAHs bed size flexibility;
• Reimstate CAH necessary provider status;
• Remove unreasonable restrictions on CAHs’ ability to rebuild; and
• Preserve the 340B Drug Pricing Program and oppose any attempts to scale back this vital program.

Regulatory Policy Priorities

Critical Access Hospitals. Recent recommendations, if implemented through legislation, will challenge the continued viability of many CAHs and threaten beneficiaries’ access to care in rural America.
and medical staffs, working together, should be able to
stories, we convinced CMS that unified medical staffs
medical staff. Using CMS data as well as AHA-member
proposed to require each hospital to have its own distinct
integrated, unified medical staff structures. CMS originally
persuade CMS to allow multihospital systems composed
advocated for a number of important changes aimed at
requirements for hospitals, CAHs and other providers.
issued a final rule to revise certain existing Medicare
Conditions of Participation (CoPs).

•  The HHS Office of Inspector General (OIG) issued a 34-


Continued


In April, President Obama released a budget outline
fiscal year (FY) 2015. The budget proposal called
for substantial Medicare and Medicaid cuts over the
next 10 years. In addition, the administration proposed
changes to payments for CAHs. Starting in FY 2015, it
would reduce CAH payments from 101 percent to 100
percent of reasonable costs and eliminate the CAH
designation for hospitals that are less than 10 miles
away from the nearest hospital.

•  The HHS Office of Inspector General (OIG) issued a 34-


•  CMS has recently indicated that it will begin enforcing a
condition of payment for CAHs that requires a physician to
certify that a beneficiary may reasonably be expected to be
discharged or transferred to a hospital within 96 hours after
admission to the CAH. If enforced, CAHs would be forced
to eliminate these “96-hour plus” services, and the resulting
financial pressure on CAHs would severely affect their ability
to operate and care for beneficiaries in rural communities.
The AHA supports the Critical Access Hospital Relief Act
of 2014 (H.R. 3991, S. 2037), which would remove this
96-hour physician certification requirement as a condition
of payment for CAHs. If passed, a physician would not
be required to state that the patient will be discharged or
transferred in less than 96 hours in order for the CAH to be
paid on that particular claim. CAHs would continue to need
to meet the other certification requirements that apply to all
hospitals as well as the condition of participation requiring a
96-hour annual average length of stay.

The AHA continues to strongly advocate to maintain the
current CAH program, and also for fixes to payment and
administration limitations that constrain the efficiency and
effectiveness of these essential health care providers.

Conditions of Participation (CoPs). In May, CMS
issued a final rule to revise certain existing Medicare
requirements for hospitals, CAHs and other providers.
Overall, the AHA was pleased with the rule, as we had
advocated for a number of important changes aimed at
reducing burden and eliminating obsolete regulations.

Most significantly, the AHA led the advocacy efforts to
persuade CMS to allow multihospital systems composed
of separately Medicare-certified hospitals to have
integrated, unified medical staff structures. CMS originally
proposed to require each hospital to have its own distinct
medical staff. Using CMS data as well as AHA-member
stories, we convinced CMS that unified medical staffs
can increase quality of care, and that hospital leaders
and medical staffs, working together, should be able to
weigh the benefits of a variety of medical staff structures
and determine what framework will best enable them to
provide high-quality care to patients.

We also were pleased that CMS rescinded on overly-
prescriptive regulation relating to hospital governing body
composition. Specifically, CMS removed a CoP requirement
that hospital governing bodies must include a member of
the medical staff and replaced it with a requirement for direct
consultation between hospital governing bodies and medical
staffs. While many hospital governing bodies already include
a medical staff member, CMS’s original requirement would
have been difficult to meet in circumstances where boards
are elected or appointed. Moreover, we did not agree that a
federal government entity should prescribe the composition
of hospital governing boards.

The AHA also supported changes finalized for CAHs
that: (1) removed a requirement for the participation of a
non-CAH staff member in the development of patient care
policies, and (2) modified the requirements for the on-
site presence of a doctor of medicine or osteopathy, but
maintain other requirements for doctors.

Electronic Health Records (EHRs) and Meaningful
Use. CMS has established confusing meaningful use rules complicated by voluminous additional guidance, as
well as a challenging operational structure. In addition,
the final Stage 2 rules raise the bar even higher while all
hospitals must upgrade to the 2014 Edition Certified EHR
this fiscal year, straining vendor capacity. In late August,
CMS finalized a rule providing limited flexibility in 2014.
Unfortunately, the rule offers little relief because the agency
did not grant a shorter reporting period for FY 2015, which
begins on Oct. 1. The AHA is very disappointed that
hospitals will be required to use the 2014 Edition EHR in
FY 2015 and report on a full year of performance, rather
than the 90-day reporting period we had recommended.
(Hospitals in their first year of participation will have a 90-
day reporting period.) For PPS hospitals, CMS will assess
penalties beginning in FY 2015 based on whether a hospital
met meaningful use in an earlier time period. For CAHs, the
penalties will be based on same-year performance.

The AHA continues to work with CMS to clarify
requirements and reduce the burden of registering and
attesting to meaningful use. We are especially pleased
that CMS has announced a reversal of its policy and will
allow CAHs to include capital leases as allowable costs
in determining their meaningful use incentive payment.
CMS also will provide expanded hardship exceptions for
hospitals that cannot meet meaningful use in an earlier time period. For CAHs, the
penalties will be based on same-year performance.

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CMS also will provide expanded hardship exceptions for
hospitals that cannot meet meaningful use in an earlier time period. For CAHs, the
penalties will be based on same-year performance.

However, we continue to be concerned about the impact
of the program on small and rural providers, and believe
that the EHR incentives program should close, not widen,
the existing digital divide. Data from CMS indicate that
CAHs, in particular, have found it more challenging to meet
meaningful use than their urban counterparts, partly due to
limited vendor choice and capacity.
FACTSHEET

Expired Medicare Provisions

THE ISSUE
Over the years, Congress has enacted several provisions to address the special challenges rural and other hospitals encounter in delivering health care services to the communities they are committed to serving. Most recently, Congress passed the Protecting Access to Medicare Act of 2014 (PAMA), which contained many provisions important to hospitals. Yet a number of programs critical to hospitals will expire this year or already have expired.

AHA POSITION
These provisions are critical and must be further extended and, in some cases, made permanent.

WHY?
These programs are of critical importance to hospitals and the patients and communities they serve. It is often difficult for hospitals to plan for community and patient needs when there is uncertainty over whether a program will continue. For these reasons, it is necessary that Congress extend these important provisions.

KEY PROVISIONS

Medicare-dependent Hospital (MDH) Program
The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. Additionally, rural residents on average tend to be older, have lower incomes and suffer from higher rates of chronic illness than their urban counterparts. This greater dependence on Medicare may make certain rural hospitals more financially vulnerable to prospective payment. To reduce this risk and support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, Congress established the MDH program in 1987. The approximately 200 MDHs are paid for inpatient services using the sum of their prospective payment system (PPS) payment rate plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. These payments allow MDHs greater financial stability and leave them better able to serve their communities. This program expires March 31, 2015.

Low-volume Adjustment
The Patient Protection and Affordable Care Act (ACA) improved the then low-volume adjustment for fiscal years (FYs) 2011 and 2012. For these years, a low-volume hospital was defined as one that was more than 15 road miles (rather than 35 miles) from another comparable hospital and had up to 1,600 Medicare discharges (rather than 800 total discharges). An add-on payment was given to qualifying hospitals, ranging from 25 percent for hospitals with fewer than 200 Medicare discharges to no adjustment for hospitals with more than 1,600 Medicare discharges.

Medicare seeks to pay efficient providers their costs of furnishing services. However, certain factors beyond providers’ control can affect the costs of furnishing services. Patient volume is one such factor and is particularly relevant in small and isolated communities where providers frequently cannot achieve the economies of scale possible for their larger counterparts. Although a low-volume adjustment had existed in the inpatient PPS prior to FY 2011, the Centers for Medicare & Medicaid Services (CMS) had defined the eligibility criteria so narrowly that only two to three hospitals qualified each year. The improved low-volume adjustment in the ACA better accounts for the relationship between cost and volume, helps level the playing field for low-volume providers, and sustains and improves access to care in rural areas. This program expires March 31, 2015.

Continued on reverse
Ambulance Add-on Payments

Small patient volumes and long distances put tremendous financial strain on ambulance providers in rural areas. To help alleviate this situation and ensure access to ambulances for patients in rural areas, the Medicare Prescription Drug Improvement and Modernization Act increased payments by 2 percent for rural ground ambulance services and also included a super rural payment for counties in the lowest 25 percent in population density. Congress, in the Medicare Improvements for Patients and Providers Act, raised this adjustment to 3 percent for rural ambulance providers.

Congress appropriately decided that these additional rural payments were necessary and important because rural ambulance providers incur higher per-trip costs because of longer travel distances and fewer transports of patients. These provisions ensure that ambulance services are more appropriately reimbursed and that beneficiaries in rural and super rural areas will have access to emergency transport services. These provisions expire March 31, 2015. In addition, the law calls for the Secretary of Health and Human Services to undertake studies on ambulance costs.

Outpatient Therapy Caps

Medicare currently sets annual per beneficiary payment limits for outpatient therapy services (physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP)) provided by therapists and other eligible professionals in certain settings. The law allows for an exceptions process to the cap if the therapy is deemed medically necessary. This exceptions process has been extended numerous times in legislation.

In 2012, the Middle Class Tax Relief and Job Creation Act temporarily expanded the therapy cap to services provided in hospital outpatient departments (HOPDs) from Oct. 1 through Dec. 31, 2012. The American Taxpayer Relief Act (ATRA) continued the temporary expansion of the therapy cap to services provided in HOPDs through Dec. 31, 2013, and further extended the therapy cap exceptions process through Dec. 31, 2013. PAMA provided further extensions and the provisions now expire on March 31, 2015.

In addition, the ATRA required CMS to count therapy services furnished by a critical access hospital (CAH) toward the therapy cap through Dec. 31, 2013. As a result of the ATRA, in the Physician Fee Schedule final rule for calendar year 2014, CMS reassessed and reversed its longstanding interpretation of existing statute by subjecting CAHs to the therapy cap beginning Jan. 1, 2014.

While the AHA supports further extending the outpatient therapy exceptions process, we oppose expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.

Outpatient Hold-harmless Payments for Small Rural Hospitals and Sole Community Hospitals

When the outpatient PPS was implemented, Congress made certain rural hospitals with 100 or fewer beds eligible to receive an additional payment adjustment, referred to as “hold harmless” transitional outpatient payments (TOPs). “Hold harmless” TOPs were intended to ease the transition from the prior reasonable cost-based payment system to the outpatient PPS. That provision originally expired Jan. 1, 2004; however, because of concerns about the financial stability of these small rural hospitals, Congress has extended the provision every year since and has subsequently expanded it to apply to equally vulnerable sole community hospitals (SCHs). It is important to note that not every eligible hospital benefits from the hold harmless every year; instead, it is only those whose costs exceed their payments during that cost year.

Hospitals that receive TOPs already have Medicare payments that are well below their Medicare costs, with payments averaging about 82 percent of costs. With the expiration of this provision, TOPs-eligible hospitals are subject to a cut of about 16 percent to Medicare outpatient payments. With such a large gap between payments and costs, it will be difficult for these vulnerable hospitals to continue to provide access to critical outpatient services, such as emergency department services and chemotherapy. This program expired Dec. 31, 2012, for rural hospitals and SCHs with no more than 100 beds. It expired March 1, 2012, for SCHs with more than 100 beds. TOPs needs to be re-instated.
96-Hour Physician Certification Requirement for Critical Access Hospitals

BACKGROUND
There is a Medicare condition of participation related to length of stay for critical access hospitals (CAHs), which requires CAHs to provide acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient. There also is a separate, and distinct, condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. Although the Centers for Medicare & Medicare Services (CMS) enforces the condition of participation, the agency historically has not enforced the condition of payment. CMS recently published guidance, in relation to its new two-midnight admissions policy, that implies the agency will begin enforcing this condition of payment going forward.

AHA POSITION
AHA supports the Critical Access Hospital Relief Act of 2014 (H.R. 3991/S. 2037), which would remove the 96-hour piece of the physician certification requirement as a condition of payment. CAHs would still be required to satisfy the other physician certification requirements. The condition of participation requiring CAHs to maintain a 96-hour annual average length of stay per patient also would remain in place.

WHY?
- While CAHs typically maintain an annual average of 96 hours per patient, they offer some medical services that have standard lengths of stay greater than 96 hours. Therefore, in those cases, the CAH will not satisfy the condition of payment because a physician will be unable to reasonably certify that the beneficiary’s stay will be less than 96 hours.

- If this condition of payment is enforced by CMS, CAHs will no longer receive payment from CMS for medical services requiring a beneficiary stay of longer than 96 hours – an untenable situation for providers and patients alike. Medicare payments account for roughly 47 percent of total revenues for CAHs and any changes in these payments are difficult to absorb.

- If CAHs are forced to eliminate these “96-hour plus” services, the resulting financial pressure on CAHs would severely affect their ability to operate and care for beneficiaries in rural communities.

- This unenforced condition of payment is in statute. Therefore, a legislative change is required in order for it to be modified or removed.

- CAHs play an essential, and often life-saving, role in our nation’s health care landscape. It is imperative that the condition of payment be removed so that CAHs may continue to provide these important health care services to rural America.
FACTSHEET

Supervision of Hospital Outpatient Therapeutic Services

THE ISSUE

In the 2009 outpatient prospective payment system (PPS) final rule, the Centers for Medicare & Medicaid Services (CMS) mandated a new policy for “direct supervision” of outpatient therapeutic services that hospitals and physicians recognized as a burdensome and unnecessary policy change. CMS’s policy required that a supervising physician be physically present in the department at all times when Medicare beneficiaries receive outpatient therapeutic services.

Further, CMS characterized the change as a “restatement and clarification” of existing policy in place since 2001. As a result, hospitals and critical access hospitals (CAHs) found themselves at increased risk for unwarranted enforcement actions, particularly brought by opportunistic whistleblowers claiming that hospitals did not have appropriate direct physician supervision arrangements in place in some or all of its affected departments dating back to 2001.

Through multiple letters, meetings and other advocacy in the intervening years, the AHA and other national hospital and physician organizations have urged CMS to rescind or significantly modify the policy and to mitigate the new and inappropriate enforcement risks that its “clarification” created. At the urging of the AHA and others, CMS has since adopted several positive changes in the regulations. Specifically, the agency has:

■ Delayed enforcement of the direct supervision policy through 2013 for CAHs and small and rural hospitals with fewer than 100 beds. Please note that since Jan. 1, 2014, CMS has permitted its contractors to enforce the direct supervision policy in all hospitals and CAHs.
■ Allowed certain types of non-physician practitioners (NPPs) to provide direct supervision for hospital outpatient services, according to their state license and scope of practice and hospital- or CAH-granted privileges. This includes physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives and licensed clinical social workers;
■ Modified the definition of direct supervision to remove all references to the physical boundaries within which the supervising professional must be located as long as he or she is “immediately available to furnish assistance and direction throughout the performance of the procedure;”
■ Adopted a two-tiered policy for the supervision of certain “nonsurgical extended duration therapeutic services” such as observation services and various infusions and injections. This policy requires direct supervision only for the initiation of the service, followed by general supervision once the patient is medically stable; and,
■ Established an independent review process that allows the Advisory Panel on Hospital Outpatient Payment (HOP Panel) to recommend, and CMS to adopt, alternate supervision levels, including general supervision, for individual hospital outpatient therapeutic services. CMS added four new members to the HOP Panel to represent CAHs and small and rural PPS hospitals. Based on recommendations made by hospitals that presented at previous HOP Panel meetings, CMS reduced the level of supervision for 56 outpatient therapeutic services from “direct” to “general” supervision.

AHA POSITION

The AHA is deeply disappointed that, despite our urging, CMS has moved forward with enforcement of its direct supervision policy in all hospitals and CAHs as of Jan. 1, 2014. Given the shortage of medical professionals, this policy may force small and rural hospitals and CAHs to limit their hours of operation or cut services to comply with the provision, resulting in reduced access to outpatient care in communities across America. The AHA will continue to urge Congress to provide relief from this short-sighted policy. The following important changes are included in AHA-supported legislation, the Protecting Access to Rural Therapy Services Act of 2013 (S. 1143/H.R. 2801):

■ Adopt a default standard of “general supervision” for outpatient therapeutic services and supplement with a reasonable exceptions process with provider input to identify those specific procedures that require direct supervision;
■ Ensure that for CAHs the definition of “direct supervision” is consistent with the CAH conditions of participation (CoP) 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 Jan. 1, 2001.
WHY?

- In an environment of continuing shortages of health care professionals, particularly in rural areas, the direct supervision requirement will be difficult to implement for hospitals and CAHs, will reduce access and is clinically unnecessary. It will require hospitals to engage more physicians and NPPs for direct supervisory coverage without a clear clinical need and create patient access problems if hospitals are forced to discontinue or limit the hours of certain outpatient services.

- CMS’s view that this policy has applied to outpatient therapeutic services furnished since 2001 opens up the entire hospital community to misplaced enforcement scrutiny, including potential recoupments and whistleblowers who can claim that a hospital did not have appropriate direct physician supervision arrangements in place in some or all of its affected departments dating back to 2001.

- Direct supervision is not a requirement of the Medicare hospital CoPs and, in fact, the rules contradict the CoPs for CAHs. One CAH CoP requires a physician or NPP to be available by phone, but not necessarily physically present on the CAH campus. In order to ensure access to hospital emergency care in these otherwise underserved areas, another CAH CoP has long required only that a physician or NPP be able to arrive within 30 minutes of a request from the staff in the facility. Therefore, CAHs may meet the CoPs yet be non-compliant with direct supervision regulations.

KEY FACTS

Hospital outpatient therapeutic services have always been provided by licensed, skilled professionals under the overall direction of a physician and with the assurance of rapid assistance from a team of caregivers, including a physician, should an unforeseen event occur. While hospitals recognize the need for direct supervision for certain outpatient services that pose high risk or are very complex, CMS’s policy generally applies to even the lowest risk services.

The HOP Panel. The HOP Panel is an independent review body that considers stakeholder testimony and advises CMS regarding whether it is appropriate to change the level of supervision for individual hospital outpatient therapeutic services – from direct to either general or personal supervision – so as to ensure an appropriate level of quality and safety for the delivery of patient care.

The current definitions for the three levels of supervision that are relevant to the HOP Panel are:

- **Direct supervision** means that the physician or NPP must be immediately available to furnish assistance and direction throughout the performance of the procedure. The physician or NPP is not required to be present in the room when the procedure is performed.

- **General supervision** means the procedure is furnished under the physician’s or NPP’s overall direction and control, but the physician’s or NPP’s presence is not required during the performance of the procedure.

- **Personal supervision** means a physician or NPP must be in the room during the procedure.

In the 2014 outpatient PPS final rule, CMS ended its moratorium on enforcement of the direct supervision policy for outpatient therapeutic services provided in CAHs and small and rural PPS hospitals with 100 or fewer beds. This means that CMS and its contractors have been permitted to enforce the direct supervision policy in all hospitals and CAHs since Jan. 1, 2014. While the AHA will continue to urge Congress to provide relief from this policy, hospitals with an interest in this issue are strongly encouraged to consider providing testimony before the HOP Panel at its August meeting.
THE ISSUE

The Medicare Disproportionate Share Hospital (DSH) program has, since its inception in the 1980s, provided vital financial support to hospitals that serve the nation’s most vulnerable populations – Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and underinsured. Congress legislated these additional payments to partially address the financial burden on hospitals serving a disproportionately high percentage of low-income and uninsured patients. Because the Patient Protection and Affordable Care Act (ACA) was estimated to expand public and private health care coverage to 32 million more Americans by 2019, Congress deemed it appropriate to cut Medicare DSH payments to hospitals, reasoning that hospitals would care for fewer uninsured patients as health coverage is expanded. Specifically, the ACA reduces Medicare DSH payments by $22.1 billion from fiscal year (FY) 2014 through FY 2019. However, with the uncertainty of the new marketplaces and Medicaid expansion, the promise of health care coverage improvements may not be realized for some years to come.

AHA POSITION

Support the DSH Reduction Relief Act of 2013 (H.R. 1920/S. 1555), which would delay DSH cuts for two years to allow for coverage expansions to be more fully realized and better data to become available.

WHY?

- The Supreme Court decision on the ACA’s Medicaid expansion will result in fewer covered individuals. The Court’s 2012 decision ruled that the federal government could not force states to expand their Medicaid programs or risk losing all of their Medicaid funding. As of December 2013, 27 states and the District of Columbia are expanding their Medicaid programs. As a result, according to recent Congressional Budget Office (CBO) projections, the ACA will expand coverage to only 25 million – rather than 32 million – individuals.

- The launch of the new insurance marketplaces is slower than projected due to operational challenges. The marketplaces began enrolling individuals on Oct. 1 with a very public and rocky launch. Much of the success of the marketplaces depends on the interoperability of information systems to determine eligibility for subsidies, verification of income through the federal information hub, and determination of Medicaid eligibility, as well as successful outreach enrollment programs. More than half of the new marketplaces are operating as federal exchanges. The operational challenges facing the marketplaces make it difficult to predict how many will be covered in the first, and perhaps second, year.

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**KEY FACTS**

Even under the current levels of DSH funding, hospital costs for providing care to Medicaid beneficiaries, low-income Medicare beneficiaries, the uninsured and the underinsured are not fully met. Medicare on average covers only 86 cents of every dollar treating Medicare patients. And in 2012, hospitals provided $46 billion of uncompensated care.

**Medicare DSH Facts**

The ACA made changes to Medicare DSH payments beginning in FY 2014. Specifically, it requires that hospitals initially receive 25 percent of the Medicare DSH funds they would have received under the traditional formula, with the remaining 75 percent flowing into a separate funding pool for Medicare DSH hospitals. This pool will be reduced as the percentage of uninsured declines and will be distributed based on the proportion of total uncompensated care each Medicare DSH hospital provides.

CMS issued its final FY 2014 inpatient prospective payment system (PPS) rule on Aug. 2, which contained its finalized rules for implementing the new Medicare DSH policy.

**Empirically justified DSH payments.** CMS will distribute 25 percent of Medicare DSH funds in the exact manner in which Medicare DSH payments have historically been distributed: through a hospital-specific percentage add-on applied to the base diagnosis-related group (DRG) payment rates. Consequently, a hospital's DSH payments will be tied to its volume and mix of PPS cases. The add-on is determined by a formula that is calculated as the sum of two ratios: (1) Medicaid patient days as a share of total patient days; and (2) Medicare Supplemental Security Income (SSI) days as a percentage of total Medicare days.

**Uncompensated care DSH payments.** CMS reduced the 75 percent pool by about $546 million in FY 2014. CMS continued these ACA mandated cuts in FY 2015 and indication that payments will be reduced by 1.3% in FY 2015 compared to FY 2014. In addition, the funds will be redistributed using inpatient days of Medicaid beneficiaries plus inpatient days of Medicare SSI beneficiaries as a proxy for measuring the amount of uncompensated care hospitals provide. CMS will distribute these payments on a per-discharge basis.

CMS considered using charity care, bad debt and other data from the hospital cost report worksheet S-10 to measure uncompensated care. However, due to concerns that the revised S-10 is relatively new and has not historically been used for payment purposes, the agency decided that its use was not appropriate at this time.
FACTSHEET

Hospital Readmissions Reduction Program

THE ISSUE

The Affordable Care Act (ACA) required the Centers for Medicare & Medicaid Services (CMS) to penalize hospitals for “excess” readmissions when compared to “expected” levels of readmissions, beginning on Oct. 1, 2012.

In fiscal year (FY) 2013, payment penalties were based on hospital readmissions rates within 30 days for heart attack, heart failure and pneumonia. In 2015, CMS will add readmissions for patients undergoing hip or knee replacement, and in 2016, readmissions for patients with chronic obstructive pulmonary disease. CMS is likely to add other measures in the future.

AHA POSITION

America’s hospitals are focused on reducing unnecessary readmissions. However, the Hospital Readmissions Reduction Program (HRRP) is deeply flawed and must be reformed to adequately account for socioeconomic factors of communities and appropriately exclude unrelated readmissions that are not related to the initial admission. AHA supports the Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2014 (H.R. 4188) and the Hospital Readmissions Program Accuracy and Accountability Act of 2014 (S. 2501), which would adjust the HRRP to account for certain socioeconomic and health factors that can increase the risk of a patient’s readmission.

WHY?

- The formula fails to account for sociodemographic factors, depriving the neediest hospitals and their patients of critical resources. A body of research demonstrates that readmissions are higher in communities that are economically disadvantaged. Koenig and colleagues demonstrated this relationship in Health Services Research in 2013, as shown in the chart below. Hospitals with the highest proportion of dually eligible patients constitute the lowest proportion of hospitals without a penalty and the highest proportion of hospitals with the largest penalties. A Kaiser Health News analysis of FY 2013 readmissions penalties showed that hospitals serving the poorest patients were more likely to incur a penalty, that penalty was more likely to be the maximum penalty.

<table>
<thead>
<tr>
<th>Distribution of Medicare Payment Reduction by Quartiles of Hospitals, based on proportion of Medicare/ Medicaid Dually Eligible Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
</tr>
<tr>
<td>2.1 - 3.0</td>
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The ACA requires that inpatient prospective payment system hospitals with higher-than-expected readmissions rates will experience decreased Medicare payments for all Medicare discharges. Critical access hospitals and post-acute care providers are exempt.

Performance evaluation is based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program and reported on Hospital Compare. The base inpatient payment for hospitals with actual readmission rates higher than their Medicare-calculated expected readmission rates are reduced by an adjustment factor that is the greater of:

- A hospital-specific readmissions adjustment factor based on the number of readmitted patients in excess of the hospital’s calculated expected readmission rate; or
- 0.98 in FY 2014 and 0.97 in FY 2015 and beyond.

This means the largest potential reduction for a hospital would be 2 percent in FY 2014; and 3 percent in FY 2015 and beyond. These reductions apply to all Medicare discharges. Hospitals with a small number of applicable patient cases, as determined by the Secretary of Health and Human Services, are excluded.

Beginning in FY 2015, the law allows the secretary to expand the list of conditions and the secretary has chosen to add chronic obstructive pulmonary disorder and total hip and knee replacement. The secretary is directed to seek endorsement from the National Quality Forum for all measures used to assess readmissions performance. If the problems with the program are not fixed now, they will likely create even more serious challenges for hospitals.

**KEY FACTS**

- The Medicare Payment Advisory Commission (MedPAC) concurs that changes need to be made to the HRRP. In June 2013, MedPAC urged Congress and CMS to make changes to the program, including altering the calculation of the payment penalties to recognize that sociodemographic factors affect the likelihood that a patient will be readmitted.

- The policy penalizes hospitals for unrelated admissions that occur within 30 days of the original hospitalization. Readmissions unrelated to the initial reason for admission should be excluded from the readmission measures. Although the ACA requires that unrelated readmissions be excluded from the program, CMS has not fully implemented this policy. For example, a patient may be hospitalized for pneumonia, and then readmitted within 30 days for a hip fracture, which is clearly unrelated to the pneumonia. The current measures would count this readmission against the hospital.
Inpatient rehabilitation facilities (IRFs) have faced significant scrutiny from Congress and the Centers for Medicare & Medicaid Services (CMS) in recent years, which has led to multiple interventions, including strict criteria for IRF patients, multiple payment cuts and other policy restrictions. Collectively, these interventions have reshaped the population treated in IRFs by dramatically reducing the overall volume of IRF patients and steadily increasing the medical complexity of patients treated in this distinct setting. The president’s 2015 budget proposes three IRF cuts: returning the 60% Rule threshold back to 75 percent; paying IRFs a lower rate for selected patients who are also treated in skilled nursing facilities (SNFs); and cutting the annual market basket update. The proposals ignore these fundamental IRF shifts, and are now, in fact, unnecessary and detrimental to patients’ access to the unmatched services provided by IRFs.

**AHA POSITION**

**Reject further payment cuts for inpatient rehabilitation hospitals and units.**

**WHY?**

- **Raising the “60% Rule” threshold is unnecessary since existing IRF admission rules strictly control who is admitted into an IRF.** These rules, implemented in January 2010, clearly set the IRF patient population apart from that of other post-acute settings, as shown in the table below. In addition, Medicare ensures that IRFs are admitting the right patients through audits. The president’s proposal overlooks the substantial reduction in the number of beneficiaries admitted annually to IRFs over the last 10 years – 122,000 fewer cases per year. It also ignores the fact that IRFs continue to treat sicker patients every year and produce better outcomes than SNFs. Further, compliance with the 60% Rule will become more challenging beginning October 2014, when CMS reduces by 20% the ICD-9-CM codes that qualify under the 60% Rule.

- **Medicare must not require IRFs to provide hospital-level services, but pay them SNF rates.** IRFs provide unique clinical value for patients who require hospital-level care and intensive rehabilitation after an illness, injury or surgery. Only in an IRF do beneficiaries receive three or more hours of therapy per day as part of a plan of care that is developed and overseen by a specialty physician and carried out by an inter-disciplinary medical team. As a result, the patient population and scope of services found in IRFs are highly distinct from those found in SNFs. IRF patients are medically complex and must require both hospital-level care and intensive rehabilitation services, which are not found in SNFs.
Continued

AHA has weighed in on recent MedPAC analysis regarding IRF-SNF site-neutral payment, under which IRFs would be paid a SNF-like rate for targeted cases that are treated in both settings, and for which selected IRF regulations (3-hour rule, 60% Rule) would be waived. For now, since MedPAC has incorporated the key principle of regulatory relief for any potential site-neutral cases, AHA supports a “cautious exploration” of IRF-SNF site-neutral payment, if the following concerns are addressed. Any future exploration by MedPAC of IRF-SNF site-neutral payment should use the most recent data to compare patients treated in both settings, and avoid a sole reliance on the prior acute-care hospital discharge diagnosis to find similar IRF and SNF patients. In addition, AHA urged MedPAC to incorporate robust risk adjustment; capture the longer SNF average lengths of stay; and apply site-neutral payment only to conditions that fall outside the IRF “60% Rule.” AHA also urged that any future IRF-SNF site-neutral policy exclude stroke patients, as suggested by MedPAC commissioners, and remove key Medicare regulations such as the 3-hour rule and other requirements for more intensive IRF care.

KEY FACTS

IRFs treat clinically appropriate patients and offer higher intensity services than SNFs.

IRFs Treat Hospital-level Patients Only:
- In 2010, CMS implemented strict IRF admission criteria mandating that every patient require both hospital-level care and intensive rehabilitation. Therefore, IRFs are not allowed to admit SNF-level patients.
- The new criteria make the IRF patient population unique from patients in all other post-acute settings. SNFs and other post-acute settings do not have similarly rigorous admission criteria.

IRFs and SNFs Are Not Interchangeable:
- CMS reported in 2011 that IRFs have a far higher rate of discharging patients to the community (IRFs: 81%; SNFs: 46%); and far lower readmission rates (IRF: 9.4%; SNF: 22.0%).
- Medicare mandates that IRF physicians direct care delivery by interdisciplinary medical teams, which are not present in SNFs.
- Most nursing care in IRFs is provided by specially trained registered nurses (RNs), a far higher level of nursing care than that provided in most SNFs.
- IRF patients must need and receive at least three hours of therapy per day, five days per week.
- IRFs, unlike other post-acute settings, submit admission and discharge data that demonstrate their value to beneficiaries. These data show IRF patients are continuing to experience improved functional outcomes – even as overall IRF patient complexity has increased.

IRF Volume Has Dropped Due to Regulatory Interventions:
- Through the 60% Rule, payment cuts, and new patient/facility criteria, Congress and CMS have significantly decreased the number of Medicare patients and payments for IRFs.
- Annual volume of IRF discharges dropped 123,712 cases from 2004 to 2011.
- The volume of IRF discharges has dropped significantly from 2004 through 2011 – 122,000 fewer cases per year.
**IRFs vs. SNFs**

<table>
<thead>
<tr>
<th>Required by Medicare</th>
<th>IRFs</th>
<th>SNFs</th>
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<tbody>
<tr>
<td>Close medical supervision by a physician with specialized training</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>24-hour rehabilitation nursing</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Multidisciplinary team approach</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3 hours of intensive therapy; 5 days per week</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Patients must require hospital-level care</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Physician approval of preadmission screen and admission</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Medical care and therapy provided by a physician-led multidisciplinary medical team including specialty trained registered nurses</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Discharge rate to community</td>
<td>69.9% (2012)</td>
<td>30.6% (2012)</td>
</tr>
<tr>
<td>2012 Medicare fee-for-service spending</td>
<td>$6.7 billion</td>
<td>$26.2 billion</td>
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THE ISSUE

Long-term care hospitals (LTCHs) serve a critical role within the Medicare program by treating the sickest patients who need long hospital stays. In December 2013, Congress passed the Bipartisan Budget Act, which, among other changes, implements several important reforms that will more clearly distinguish the LTCH role. These include a new, two-tiered payment system beginning in October 2015, under which LTCHs will be paid an LTCH-level rate for patients with higher severity of illness levels, and a lower, “site-neutral” rate (comparable to general acute care hospitals) for patients with lower medical acuity.

In addition, the new law addresses the “25% Rule”, established by the Centers for Medicare & Medicaid Services to limit referrals from one source, by implementing more manageable “25% Rule” thresholds for cost reporting periods beginning Oct. 1, 2013 through Sept. 30, 2017.

AHA POSITION

The AHA has long supported the development of criteria to distinguish LTCHs from general hospitals and other post-acute settings. The new LTCH criteria in the Bipartisan Budget Act will appropriately focus Medicare’s LTCH resources on sicker patients. We also support the 25% Rule relief provided under this law, which will implement less burdensome levels of the policy to allow the field to focus on transitioning to the new payment system and to prepare for broader delivery system reforms, such as bundled payments. Overall, the Bipartisan Budget Act will bring much-needed regulatory stability that will ensure access for the beneficiaries who need an extended hospital stay. However, some LTCH policies in the Bipartisan Budget Act will likely require further technical adjustments to ensure the effective and fair implementation of the law.

WHY?

While the AHA is pleased that Congress addressed this issue, some of the LTCH policies in the Bipartisan Budget Act require ongoing monitoring due to the scale and complexity of change under this law. In the Protecting Access to Medicare Act of 2014, Congress implemented an initial round of LTCH technical corrections. Further adjustments may be warranted as the field continues plans to transition to the new two-tiered system. One potential adjustment pertains to the definition of the cases that remain eligible for payment under the traditional LTCH prospective payment system (PPS). Under this law, LTCH PPS payments will apply to cases that, in the immediately prior inpatient PPS hospital stay, received either 3+ intensive care unit days of service or were discharged with a principle diagnosis based on 96+ hours of ventilator services. The AHA will continue to monitor the implementation of the new LTCH PPS criteria and the need for additional technical corrections.

Continued on reverse
**KEY FACTS**

**LTCHs Treat Severely Ill Patients**

The LTCH patient population is more severely ill than patients treated in general acute care hospitals. Data from general acute hospitals show that patients discharged to LTCHs have the highest medical severity when compared to patients in other settings. For example, 50 percent of inpatient PPS patients discharged to an LTCH have a severity of illness (SOI) level 4 (extreme severity) compared to only 37 percent of patients in ICUs. Since LTCH patients are typically far sicker, their average length of stay (ALOS) is much longer: 27.2 days for LTCHs, 5.1 days for general acute hospitals, and 6.7 days for ICUs in general acute hospitals.

![Severity of Illness (SOI) Levels for Different Settings/Discharge Destination]

Source: Analysis of 2011 MedPAR data.
The Financial State of U.S. Hospitals

THE ISSUE

Hospitals cannot help effectively transform the health care system without a predictable revenue stream. Every time Congress grapples with a budget crisis, hospitals face the potential for additional cuts and even greater uncertainty. Since 2010, Medicare and Medicaid payments for hospital services have been slashed by more than $121.9 billion. Hospitals cannot continue to do more with less.

AHA POSITION

Congress must reject further cuts to Medicare and Medicaid funding for hospital services and support real solutions as it looks for ways to reduce spending. Specifically, we urge Congress to reject:

- Site-neutral payment policies for hospital outpatient departments
- Reductions in payments to hospitals for assistance to low-income Medicare beneficiaries (bad debt)
- Reductions to Medicare payments for graduate medical education
- Additional across-the-board cuts to Medicare inpatient hospital rates through the use of coding adjustments
- Restrictions in Medicaid provider assessments
- Reductions to rural hospital programs, including critical access hospitals
- Changes to the 340B drug pricing program

WHY?

- In 2012, hospitals provided nearly $46 billion in uncompensated care, for a total of more than $126 billion in uncompensated care since 2010.
- Underpayment by Medicare and Medicaid to U.S. hospitals was $56 billion in 2012.
  - Medicare reimbursed 86 cents for every dollar hospitals spent caring for these patients.
  - Medicaid reimbursed 89 cents for every dollar hospitals spent caring for these patients.

Since 2010, Medicare and Medicaid payments for hospital services have been slashed by more than $121.9 billion.
According to an August 2014 report from Moody's Investors Service, operating revenue growth for nonprofit hospitals dropped to an all-time low of 3.9 percent in fiscal year 2013 and was outpaced by expense growth for a second consecutive year, a trend that is “unsustainable.” Moody’s said it expects revenue growth “will remain under pressure in 2014 as many of the trends in 2013 continue and accelerate.” According to the report, factors that continue to challenge revenue growth include low rate increases from commercial payers; Medicare disproportionate share reductions; an increase in high-deductible health plans and associated bad debt; and a shift from inpatient admissions to lower reimbursed outpatient visits and observation stays.

Median financial ratios for U.S. not-for-profit health systems and stand-alone hospitals showed a decline in 2013 as volumes fell and expense growth outpaced patient revenue gains, Standard & Poor’s Ratings Services said in two August reports. The credit rating organization said the finding is consistent with its negative outlook for the sector in light of mounting challenges, including substantial investments in technology amid a period of declining volume and an evolving reimbursement environment related to health care reform. “We believe the sector is at a tipping point where negative forces have started to outweigh many providers’ ability to implement sufficient countermeasures,” said credit analyst Margaret McNamara. Standard & Poor’s rates the debt of 375 stand-alone hospitals and 139 health care systems, which include about 1,362 hospitals.

Calls for cuts to payments to hospitals are coming despite the fact that overall Medicare and Medicaid spending growth projections are down.

- The Congressional Budget Office (CBO) in August lowered its projections for Medicare and Medicaid spending over the next 10 years by $89 billion.
- The Centers for Medicare & Medicaid Services’ (CMS) Office of the Actuary in September projected an average growth rate of 5.7 percent for health care spending from 2013-23. It projected an average growth rate of 5.8 percent in its 2013 report.
- The latest indicators from the Altarum Institute’s Center for Sustainable Health Spending found hospital price growth fell to 1.9 percent in June, which “was largely responsible for pushing the aggregate health care price index lower despite rapid prescription drug price growth.”
2. Very few hospitals have attested in FY 2014 as of the end of August. According to a Centers for Medicare & Medicaid Services (CMS) presentation, only 9 percent of the 5,000 eligible hospitals have attested in FY 2014, even though the deadline is Sept. 30. Only 3 percent have attested to Stage 2. Why?

■ First, the certification process is broken. Vendor delays and implementation issues have limited hospitals' ability to attest to meaningful use this year, risking a halt to progress. Hospitals are finding that 2014 Edition Certified EHRs do not work as expected and require significant and expensive patches or workarounds. The biggest problems have been with the “transitions of care” and “patient portal” requirements.

■ Second, while certified, 2014 Edition EHRs do not share data easily, either within the hospital or across settings. They are not, generally speaking, interoperable. In addition, many areas of the country do not have efficient and affordable information exchange networks in place.

■ Third, the program requirements hold hospitals accountable for events outside of their control. For example, to meet the transitions of care requirement, a hospital must find other providers ready to receive information according to the new federal government exchange standard. Yet post-acute providers are not part of the meaningful use program, and many physicians have yet to implement their 2014 Edition EHRs.

3. The two-year cycle for meaningful use stages is too short for safe and effective implementation of new technologies. Hospitals estimate that it takes 19 months, on average, to properly and safely implement their 2014 Edition EHRs. Continuous upgrades disrupt both clinical care and operations, consume capital and delay other important initiatives, such as building out new models of care.
Four Steps to Fix the Program

The current program is overly complex and not sustainable, which means patients will not realize the benefits of a wired health care system. The following changes are needed to fix the program.

1. Allow adequate time to transition to Stage 2. A reporting period of 90 days in FY 2015 (rather than an entire year) would keep hospitals on track at a pace that supports safe implementation. It also would allow hospitals to optimize new technology for clinical care and build information sharing networks.

2. Remove specific requirements that hold hospitals accountable for the actions of others, but expect the technology to be in place. For example, a hospital must have a patient portal, but does not have to meet a specific requirement on the share of patients that use it.

3. Wait until Stage 2 is met before setting the start date or requirements for Stage 3. This is a matter of common sense when so few have met Stage 2 so far. Once 75 percent of hospitals and physicians have met Stage 2, then Stage 3 rules can be considered.

4. Fix the certification process. Make sure vendor products are interoperable. Improve how EHRs are tested so that certified products work as expected and can share data.

Five Policy Principles for Stage 3 Development

CMS and ONC must evaluate the current state of the program before writing new rules for Stage 3. After assessing experience from Stage 2, any Stage 3 policies should build on these principles so that the program moves to a mature, stable, predictable platform.

1. Allow at least three years for all hospitals and other providers at each stage. The two-year cycle is merely a regulatory structure that has created unnecessary pressures to put a timeline ahead of the outcome, leading to major market disruptions.

2. Increase flexibility in the program requirements so that a small mistake does not have a large impact. Moving forward, as mandated in statute, there are no positive incentives, only penalties. The current “all-or-nothing” approach of having to meet each and every metric, or fail altogether, is solely a regulatory design and is unfair.

3. Make sure all new requirements are truly needed. Policy should be based on definitive evidence that each requirement can be met and has benefits that clearly outweigh costs.

4. Make the electronic clinical quality measures (eCQMs) work. For hospitals, eCQMs have not, so far, produced accurate data. They need better field testing and independent review.

5. Focus on interoperability and robust testing tools to create a certification program that works.