



American Hospital
Association®

Medicare

Background

America's hospitals have a long tradition of providing care for all who seek it. But that mission is threatened by an underfunded Medicare program. Recently, the Medicare Payment Advisory Commission (MedPAC) reported that Medicare payments continue to fall well below the cost of caring for America's seniors. MedPAC estimates that aggregate Medicare hospital margins in fiscal year (FY) 2014 will be negative 6.0 percent.

At the same time, hospitals continue to face enormous changes associated with the Affordable Care Act (ACA), as well as challenges and cost pressures related to growing uncompensated care, labor shortages, the adoption of electronic health records and the administrative burden of responding to requests from myriad Medicare contractors. Hospitals also are grappling with the difficult sequestration policies set forth in a series of budget bills that require a 2 percent automatic reduction to all Medicare payments through 2024. Most recently, the Protecting Access to Medicare Act (PAMA) doubled the sequester deduction to 4 percent for the first six months of 2024, while eliminating it in the last six months. Hospitals need adequate Medicare payment to ensure that patients and communities receive the care they expect and need.

AHA View

The sequester is but one example of the federal government's reliance on arbitrarily ratcheting down provider payments to address concerns about health care spending, the deficit and related budget issues. But, ratcheting provider payments will not put the nation on a sustainable path for the future; we need real reforms, not blunt cuts to providers. The AHA's report, "Ensuring a Healthier Tomorrow," proposes targeted reforms that can improve the way we deliver care, slow the growth in health care spending and build a stronger foundation for the future. Each of the 12 recommendations has an associated list of suggested actions that providers, the government, insurers and employers, and patients can take to strengthen our health care system and our nation's finances. The report is available at www.aha.org/healthiertomorrow.

Inpatient Prospective Payment System (PPS) Rule. The AHA anticipates that, in the FY 2015 inpatient PPS proposed rule, the Centers for Medicare & Medicaid Services (CMS) will continue to implement the temporary documentation and coding cuts required by the American Taxpayer Relief Act (ATRA). These cuts address alleged payment increases related to implementing the Medicare-severity diagnosis-related group (MS-DRG) system. Specifically, CMS believes that adoption of the MS-DRGs led to coding and classification changes that increased aggregate hospital payments without a corresponding increase in actual patient severity of illness.

The ATRA requires that CMS recoup this difference from FYs 2010, 2011 and 2012 over a four-year period. These cuts began in FY 2014 when CMS implemented a cut of 0.8 percent (\$900 million); the agency then suggested that it would make additional cuts of 0.8 percent in each of FYs 2015, 2016 and 2017 to fulfill the ATRA requirement. Therefore, we anticipate an additional

documentation and coding cut of 0.8 percent for FY 2015. The agency also may re-propose the permanent documentation and coding cut of 0.8 percent that it withdrew in its FY 2013 inpatient PPS final rule due to our advocacy efforts. **Nevertheless, the AHA continues to assert that CMS has used flawed methodology and is overstating the effect of these documentation and coding changes.**

Disproportionate Share Hospital (DSH) Payments. Because the 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 reduced Medicare DSH payments by \$22.1 billion from FY 2014 through FY 2019.

CMS implemented Medicare DSH payment changes in the FY 2014 inpatient PPS final rule. The agency finalized a policy to 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 MS-DRG payment rates. CMS also finalized a policy to reduce the remaining 75-percent pool by about \$546 million in FY 2014, based on the estimated percentage decline in the uninsured. The agency is distributing these funds 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 considered instead 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. The AHA will continue to work to ensure that the modifications to the Medicare DSH program are made in accordance with the DSH principles proposed by the AHA Medicare DSH Payment Advisory Committee and adopted by the AHA Board of Trustees.

In addition, although the ACA was estimated to expand public and private health care coverage to 32 million more Americans by 2019, due to the Supreme Court decision on the ACA's Medicaid expansion and the slower than projected roll out of the new insurance marketplaces, the ACA's coverage expansion will be far less than originally projected in FYs 2014 and 2015. **Therefore, in 2014, the AHA continues to work with Congress to ensure that the DSH cuts reflect this slower realization of coverage expansion. We support the DSH Reduction Act, H.R. 1920/S. 1555, which would eliminate the first two years of the ACA's cuts to the Medicare DSH program to allow expansion of health care coverage to become more fully realized.** The bills were introduced by Rep. John Lewis (D-GA) and Sen. Roger Wicker (R-MS).

Two-Midnight/Patient Status. Whether a patient is admitted to a hospital as an inpatient or treated under outpatient observation status has implications for Medicare payment and Medicare beneficiary coverage. Traditionally, the decision to admit a patient as an inpatient has been up to the judgment of the treating physician, with oversight from the hospital and input from the patient. CMS recovery audit contractors (RACs) and Medicare administrative contractors (MACs) have repeatedly second guessed physician judgment, declaring that some patients who were admitted should not have been. This has, in turn, created ambiguity over who decides what constitutes an appropriate admission and what the criteria are for making such a determination.

In an effort to clarify that ambiguity, CMS addressed the issue of patient status in the FY 2014 inpatient PPS final rule and finalized its “two-midnight” policy whereby the agency will generally consider hospital admissions spanning two midnights as appropriate for payment under the inpatient PPS. In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. CMS also implemented 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 this policy. The policy took effect Oct. 1, 2013, but, at AHA’s urging, CMS partially delayed its enforcement through Sept. 30, 2014. The PAMA extends the delay in enforcement of the two-midnight policy for an additional six months, through March 31, 2015. During the partial enforcement delay, CMS will not be able to conduct patient status reviews on a post-payment review basis through RACs for inpatient claims with dates of admission Oct. 1, 2013 through March 31, 2015. CMS will, however, be permitted to continue its “Probe and Educate” audits, as previously specified by the agency, through March 31, 2015.

The AHA will continue to urge CMS to fix the critical flaws of the underlying policy by engaging stakeholders to find a workable solution that addresses the reasonable and necessary inpatient-level services currently provided by hospitals to Medicare beneficiaries who are not expected to span two midnights. We anticipate that CMS may request feedback on potential policy options to address this issue in the FY 2015 inpatient PPS proposed rule.

The AHA supports the Two-Midnight Rule Delay Act/Two-Midnight Coordination and Improvement Act, H.R. 3698/S. 2082, which would implement a new payment methodology for short inpatient stays in FY 2015. The bills were introduced by Reps. Jim Gerlach (R-PA) and Joseph Crowley (D-NY), and Sens. Robert Menendez (D-NJ) and Deb Fischer (R-NE).

In addition, on April 14, the AHA, several state and metropolitan hospital associations, and four hospital systems filed two-related lawsuits against the Department of Health and Human Services (HHS) challenging CMS's two-midnight policy. The lawsuits contend that the two-midnight rule and a related

offset to Medicare payments burden hospitals with unlawful arbitrary standards and documentation requirements and deprive hospitals of proper Medicare reimbursement for caring for patients.

Area Wage Index (AWI). The AWI adjusts payments to reflect differences in labor costs across geographic areas. In February 2013, the Office of Management and Budget updated its list of Core Based Statistical Areas (CBSAs), which serve as the AWI labor markets, to reflect its new 2010 standards and 2010 census data. However, this did not leave enough time for CMS to apply these updated geographic areas to the FY 2014 wage indices. Instead, we anticipate that CMS will apply the updated CBSAs in the FY 2015 inpatient rulemaking cycle.

AWI Task Force. Hospitals repeatedly have expressed concern that the inpatient PPS AWI is greatly flawed in many respects. Congress and Medicare officials also have concerns with the current system. In July 2011, the AHA Board of Trustees created a Medicare AWI Task Force to identify and evaluate the strengths and weaknesses of the current hospital wage index; develop a set of principles by which to evaluate various proposals to modify the hospital wage index, including review of AHA's existing principles; evaluate proposals and studies to change the hospital wage index; and make recommendations to improve the accuracy, fairness and effectiveness of the hospital wage index.

The task force agreed to nine principles and made seven recommendations to the AHA Board of Trustees to reform the wage index. The task force members agreed that it is unlikely that any set of recommendations would completely "fix" the wage index system for the hospital field. However, the task force felt very strongly that there are specific actions that would categorically improve the system for the field as a whole.

The AHA board recognizes that any changes to the AWI will have various effects for all hospitals. After reviewing feedback from the field on the task force report, the AHA Board of Trustees at its July 2013 meeting declined to adopt the task force's recommendations because of a lack of consensus within the hospital field. However, the AHA board wanted to make sure that others would benefit from the thorough examination of this issue. That is why the AHA board adopted principles that will guide the AHA on proposed changes to the wage index in the future and released the draft task force report, intending to add to the public policy discussion about AWI reform similar to the release of reports by CMS, the Institute of Medicine and MedPAC.

At the same time, the AHA board supported taking certain steps related to the AWI, including:

- Advocating for the task force recommendation that CMS should designate one fiscal intermediary/MAC to complete all wage index data collection and

processing to improve the accuracy and consistency of the wage index;

- Supporting CMS's planned implementation of regulatory changes based on 2010 census data to the CBSAs that are used to delineate AWI labor markets; and
- Developing and advocating for a policy that does not allow the spread between the highest and lowest wage index values to increase – for at least three years – after these census changes are adopted in FY 2015. After three years, an evaluation of the consequences of the policy should be conducted.

Outpatient PPS Rule. The calendar year (CY) 2014 outpatient PPS final rule made sweeping changes to the payment system. These changes are important, and they also have implications for the outpatient site-neutral payment proposals being considered by Congress.

Coding and Payment. In the final rule, CMS collapsed the 10 separate evaluation and management (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 that would cap "total" payment for non-emergency department E/M services in hospital outpatient departments (HOPDs) at the rate paid to physicians for providing the services in their private offices. MedPAC has not revisited its recommendation or its impact analysis since CMS finalized the E/M code collapse policy, but had estimated that its previous policy would reduce Medicare spending by \$900 million per year and \$9 billion over 10 years, thereby reducing hospital payment between 65 percent and 80 percent for 10 of the most common outpatient services. **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 recommendation to equalize Medicare payment rates for E/M services between HOPDs and physician office settings. Regardless, the AHA continues to strongly oppose such legislation.**

In addition, the 2014 outpatient PPS final rule identified five new categories of items and services whose costs are now packaged into the payment for other services to which they are integral, ancillary or supportive. This policy significantly increases the amount of packaging in all ambulatory payment classifications (APCs). Therefore, it will likely affect the impact estimates for the policy Congress is considering to cap "total" payment for a set of 66 groups of services furnished in HOPDs at the rate paid to physicians for providing the services in their private offices. At its January 2014 meeting, despite AHA's urging, MedPAC voted to formally recommend this policy without considering these

changes. However, based on its current analysis, MedPAC indicates that this would cut hospital outpatient payments by 2.6 percent, or \$1.1 billion, in one year. **The AHA strongly opposes legislative proposals to reduce Medicare payment rates for APCs to a residual amount of the physician payment rate or to the rate paid in ambulatory surgery centers.**

Physician Supervision. In the CY 2009-2013 outpatient PPS rules, CMS mandated new requirements for “direct supervision” of outpatient therapeutic services. Direct supervision requires that a physician or a non-physician practitioner (NPPs) be immediately available to furnish assistance and direction throughout the performance of the procedure. Small, rural PPS hospitals and critical access hospitals (CAHs) have expressed concern that shortages of physicians and NPPs in their communities make it difficult to comply with the direct supervision requirements.

In the 2014 outpatient PPS final rule, CMS finalized a policy to end, on Jan. 1, 2014, its prohibition on Medicare contractors enforcing the direct supervision policy for outpatient therapeutic services furnished in CAHs and in small, rural hospitals having 100 or fewer beds. For 2014, the agency, therefore, will require a minimum of direct supervision for all outpatient therapeutic services furnished in hospitals and CAHs, unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic service. **The AHA is deeply disappointed that CMS has not heeded concerns voiced by CAHs and small, rural hospitals that imposing its direct supervision policy is not only unnecessary, but will result in reduced access to care. Without adequate numbers of physicians and other health professionals in rural communities to provide direct supervision, hospitals may limit their hours of operation or close certain programs due to their inability to meet the requirements of direct supervision.**

The AHA will continue to urge Congress to provide relief from this short-sighted policy. A number of important changes that would address these concerns are included in AHA-supported legislation, the Protecting Access to Rural Therapy Services Act (S. 1143/H.R. 2801), also known as the PARTS bill, introduced by Sens. Jerry Moran, (R-KS), Jon Tester (D-MT) and John Thune (R-SD) and Reps. Kristi Noem (R-SD) and Collin Peterson (D-MN). The bill’s provisions would:

- Adopt a default standard of “general supervision” for outpatient therapeutic services.
- Develop a reasonable exceptions process with provider input to identify specific procedures that require direct supervision.
- Ensure that, for CAHs, the definition of “direct supervision” is consistent

with the CAH conditions of participation that allow a physician or NPP to present within 30 minutes of being called.

- Prohibit enforcement of CMS's retroactive reinterpretation that the "direct supervision" requirements applied to services furnished since Jan. 1, 2001.

Further, in order to give Congress more time to enact legislation like the PARTS bill, the AHA is supporting S. 1954, introduced by Sen. Jerry Moran (R-KS), and H.R. 4067, introduced by Rep. Lynn Jenkins (R-KS), that would extend through 2014 the enforcement moratorium on the outpatient therapy "direct supervision" policy for CAHs and rural PPS hospitals with 100 or fewer beds

In addition, hospitals still have an opportunity to present to the Advisory Panel on Hospital Outpatient Payment (HOP Panel) and urge it to evaluate and make recommendations to CMS on the appropriate level of supervision for outpatient therapeutic services. The HOP Panel is charged with assessing the appropriate supervision levels for individual hospital outpatient therapeutic services. As a result of the panel's past input, CMS has reduced the level of supervision for 49 outpatient therapeutic services. The next HOP Panel meeting is scheduled for the summer. **Given the importance of this issue to the field, we strongly encourage hospitals to consult with their clinical staff and request an opportunity to testify before the HOP Panel's meeting regarding additional services that could safely be downgraded to general supervision.**

Physician Payments. In 2012, America's community hospitals employed approximately 233,000 physicians, including interns and residents, and that number is growing rapidly. As physician integration efforts become more prevalent, adequate payment for professional services furnished by physicians and NPPs has become increasingly important to hospitals. The current Medicare physician payment formula is severely flawed and will result in significant payment cuts to physicians after March 31, 2015 without legislative action. The AHA will continue to work with Congress to find a permanent solution to the Medicare physician payment problem, while strongly opposing additional cuts to fund an SGR repeal that could be harmful to hospitals' ability to fulfill their mission of caring. (Refer to the AHA issue paper, "Physician Issues," for more information.)

Medicare Advantage (MA). Medicare Advantage was created as an alternative to fee-for-service Medicare. Beneficiaries can choose between traditional fee-for-service Medicare or MA plans during the annual election period, which runs from October to December, or during special election periods as deemed by CMS. MA plans must offer at least the same benefits as traditional Medicare, but they typically offer greater coverage than traditional Medicare. MA issuers are capitated by CMS for each of the beneficiaries that choose one of their plans. In addition to capitation, the MA program increases or decreases payment based on the relative risk of the issuer's covered population and offers bonuses to plans

based on their quality ratings relative to other MA plans in their market.

The MA program is the fastest growing segment of Medicare overall. More newly eligible beneficiaries are selecting plans from issuers under the managed Medicare program than choosing the traditional fee-for-service Medicare. A 2013 national study by McKinsey & Company shows that 2006-2013 compound growth for MA was 11.3 percent versus just 1.1 percent for traditional Medicare. Hospitals, therefore, are seeing a growing portion of revenue for Medicare patients coming through managed care contracts with MA issuers. These are trends that many experts believe will continue well into the future, provided that the MA program's capitated payments remain relatively stable and that MA plans continue to be offered and are affordable for most seniors. With the historical slow growth of Medicare fee-for-service costs in recent years, CMS is indicating that benchmark capitated payments will increase slightly for the 2015 plan year. Other payment and policy changes in the MA program may still result in a decline in capitation rates for MA plans. **The AHA is concerned about cuts to MA payment as those cuts impact hospitals and health systems that offer MA plans or may be passed on by issuers to providers. In addition, MA plans in recent years have reduced their networks, including hospitals, to reduce their overall medical costs and avoid premium increases or benefit reductions for beneficiaries. The AHA will continue to monitor MA trends and oppose payment offsets that would harm hospitals.**

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

However, some policymakers are advocating for a significant reduction in Medicare graduate medical education (GME) payments to teaching hospitals. Specifically, the president's FY 2015 budget called for reducing GME payments by \$14.6 billion over 10 years. This is a greater cut than the \$11 billion proposed last year. The FY 2015 budget also proposed \$5.23 billion to support 13,000 new residents through a new competitive GME program implemented by the Health Resources and Services Administration.

With the help of strong advocacy from the field, Congress has not reduced Medicare direct or indirect medical education payments to teaching hospitals. **The AHA will continue to oppose reductions in Medicare funding for GME and also advocate for maintaining existing funding for GME conducted in children's hospitals.** For more information on children's hospitals GME, see the AHA's issue paper "Annual Appropriations."

Given the current and projected shortage of physicians, especially in primary care and general surgery, the AHA continues to recommend that the 1996 cap on residency slots be lifted. Limits on the number of Medicare-funded residency training slots constrain the ability of hospitals to train new physicians. That's why the AHA supports the Resident Physician Shortage Reduction Act (S. 577/H.R. 1180), introduced by Sens. Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV), and by Rep. Joe Crowley (D-NY), respectively. The bill would increase the number of Medicare-supported physician training positions by at least 15,000 new resident positions, which is about a 15 percent increase in residency slots.

Rural Hospitals. Because of their small size, modest assets and financial reserves, and higher share of Medicare patients, rural hospitals disproportionately rely on government payments. While their Medicare margins have improved in recent years, more than 59 percent still lose money treating Medicare patients. **The AHA is pleased that Congress provided relief on certain issues as part of the PAMA. However, this law did not go nearly far enough in extending policies critical to rural hospitals. In 2014, we continue to work with Congress to provide small, rural hospitals with adequate reimbursement and remove the 96-hour condition of payment for CAHs.** For more information, see the AHA's issue paper, "Small or Rural Hospitals."

Post-acute care Providers. While many patients receive care in the physician's office or inpatient hospital settings, a variety of other settings are available to patients who need certain specialized follow-up care. These services, described collectively as post-acute care, support patients who require ongoing medical management, therapeutic, rehabilitative or skilled nursing care. This care is typically provided in long-term acute-care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and at home through home health agencies. For more information, see the AHA's issue paper, "Post-acute Care Providers."