American Hospital Association®

Legislative Advocacy Agenda

Our attention is sharply focused on March 31, the date the latest Medicare physician payment fix expires. In February, congressional leaders unveiled legislation to fix the recurring physician payment problem by repealing the sustainable growth rate (SGR) formula. The SGR Repeal and Medicare Provider Payment Modernization Act, H.R. 4015, includes a 0.5 percent payment update for five years under the fee-for-service model as a transition, as well as a provision to allow for further updates, if needed. However, the bill, which was scored by the Congressional Budget Office at $138 billion over the next 11 years, does not include recommendations on how to offset the costs.

Hospital payments are again at serious risk as a potential offset. As they look for ways to offset the cost of the permanent replacement, lawmakers are considering, a number of proposed cuts, including site-neutral payment proposals and reductions in payments to hospitals for assistance to low-income Medicare beneficiaries (bad debt), as well as reductions to payments for graduate medical education and cuts to rural hospitals.

The AHA is working to ensure that the voice of hospitals – and the patients and communities they serve – is heard. Specifically, we are working to:

- **Protect hospital payments** as legislators look for savings and potential offsets for other spending;
- **Provide relief from excessive and harmful policies,** such as the "two-midnight" policy, recovery audit contractors, the 96-hour rule for critical access hospitals, and the direct supervision policy for outpatient therapies, that undermine hospitals' ability to care; and
- **Support rural health care by extending crucial expiring policies,** including the Medicare-Dependent Hospital Program, the low-volume adjustment, and ambulance add-on payments.

As the SGR bill may be the only Medicare-related legislation to move before the November election, it is imperative that we also attempt to address some of our key legislative concerns now.

AHA Resources and Opportunities

- **Watch for *AHA Action Alerts*** on steps you can take to reach out to legislators and regulators to amplify the hospital message.
- **Visit the *AHA Action Center*** for additional news and updates, including updates to our congressional scorecard. Click here for more.
- **Plan to attend an upcoming AHA Advocacy Day in March.** Together, we can urge legislators to protect patient care. Visit *www.aha.org/advocacydays* for more details.

Key Advocacy Issues

Priority	What's Needed	Resources
The Medicare Audit Improvement Act	Introduced by Reps. Sam Graves (R-MO) and Adam Schiff (D-CA) and by Sens. Mark Pryor (D-AR) and Roy Blunt (R-MO), respectively, this bill would establish a consolidated limit for medical record requests, impose financial penalties on RACs that fail to comply with program requirements, make RAC performance evaluations publicly available and allow denied inpatient claims to be billed as outpatient claims when appropriate.	Bill Language: • H.R. 1250 • S. 1012 AHA Action Alert AHA Factsheet List of Co-sponsors AHA Infographic
The DSH Reduction Relief Act	Introduced by Rep. John Lewis (D-GA) and Sen. Roger Wicker (R-MS), this bill would eliminate the first two years of the ACA's cuts to the Medicare DSH program to allow expansion of health coverage to become more fully realized. (Congress approved a two-year delay of Medicaid DSH cuts in December.)	Bill Language: • H.R. 1920 • S. 1555 AHA Action Alert AHA Factsheet List of Co-sponsors
The Two Midnight Rule Delay Act/ Two-Midnight Coordination and Improvement Act	Introduced by Reps. Jim Gerlach (R-PA) and Joseph Crowley (D-NY), H.R. 3698 calls on the Centers for Medicare & Medicaid Services (CMS) to implement a new payment methodology for short inpatient stays in fiscal year 2015. Introduced by Sens. Robert Menendez (D-NJ) and Deb Fischer (R-NE), S. 2082 similarly calls for a new payment methodology, and also extends CMS's current partial enforcement delay through either Oct. 1, 2015, or when the agency implements criteria defining short stays, whichever is earlier.	Bill Language: • H.R. 3698 • S. 2082 AHA Regulatory Advisory AHA Comment Letter to CMS AHA Action Alert AHA Action Alert AHA Factsheet List of Co-sponsors
The Rural Hospital Access Act	Introduced by Sens. Charles Schumer (D-NY) and Charles Grassley (R-IA) and by Reps. Tom Reed (R-NY) and Peter Welch (D-VT), respectively, this bill would provide for an extension of the Medicare-Dependent hospital program and payments under the Medicare low-volume hospital program.	Bill Language: • S. 842 • H.R. 1787 AHA Action Alert AHA Factsheet List of Co-sponsors

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Priority	What's Needed	Resources
The Protecting Access to Rural Therapy Services Act	Introduced by Sen. Jerry Moran (R-KS) and by Reps. Kristi Noem (R-SD) and Collin Peterson (D-MN), respectively, this bill would protect access to outpatient therapeutic services by adopting a default standard of "general supervision" (rather than "direct supervision") for outpatient therapeutic services; creating a provider advisory panel to identify those outpatient services complex enough to require direct supervision; and holding hospitals and CAHs harmless from civil or criminal action regarding CMS's retroactive reinterpretation.	Bill Language: • S. 1143 • H.R. 2801 AHA Action Alert AHA Factsheet List of Co-sponsors
The Critical Access Hospital Relief Act	Introduced by Sens. Pat Roberts (R-KS) and Jon Tester (D-MT) and Reps. Adrian Smith (R-NE), Greg Walden (R-OR), Lynn Jenkins (R-KS) and David Loebsack (D-IA), this bill would remove the 96-hour physician certification requirement as a condition of payment for CAHs. Medicare requires physicians to certify that patients admitted to a CAH will be discharged or transferred to another hospital within 96 hours for the CAH to receive payment for the patient's services under Medicare Part A. CMS has not historically enforced the requirement, but in recent guidance related to its two-midnight admissions policy implied that it will, a situation that would threaten patients' access to longer lengths of stay when needed. The legislation would not remove the requirement that CAHs maintain an average annual length of stay of 96 hours, nor affect other certification requirements for hospitals.	Bill Language: • S. 2037 • H.R. 3991 AHA Talking Points AHA Infographic AHA Letter of Support AHA Action Alert
The Establishing Beneficiary Equity in the Hospital Readmissions Program Act	Rep. Jim Renacci (R-OH) has introduced legislation that would require CMS to takes steps to ensure that hospitals caring for the most vulnerable patients are not unfairly penalized under the Hospital Readmissions Reduction Program (HRRP). Specifically, the bill would require CMS to account for socioeconomic factors by adjusting hospital performance for the proportion of inpatients dually eligible for Medicare and Medicaid. The bill also would instructs CMS to exclude certain categories of patients (e.g., transplant, psychosis, end-stage renal disease) for whom frequent hospitalizations – and, therefore, readmissions – are often clinically necessary. This exclusion builds on the HRRP's existing exclusion of patients who are discharged against medical advice.	Bill Language: • H.R. 4188 AHA Letter of Support AHA Action Alert AHA Factsheet AHA Comment Letter Hospital Engagement Network Readmissions Work

Areas at Risk for Payment Reductions

Area of Vulnerability	AHA Position	Resources
Cuts to payments for evaluation and management services and certain other procedures provided in hospital outpatient departments (HOPDs)	Three potential site neutral payment changes have been proposed that would result in lower payments to hospitals: • paying for evaluation and management services in the HOPD setting at the physician fee schedule amount; • paying for 66 ambulatory payment classifications in the HOPD at the physician fee amount; and • capping payment for 12 procedures commonly performed in the ambulatory surgical center (ASC) setting at the ASC rate when done in the HOPD. HOPDs have higher cost structures than physician offices due to the need to have emergency stand-by capacity and the unique regulatory requirements imposed on them. Medicare margins are negative 11.2% for outpatient services. Making additional cuts to HOPD payments threatens beneficiary access to these services.	AHA Factsheet on E&M AHA Factsheet on Site-Neutral Payment AHA Infographic AHA Letter to MedPAC AHA Alliance for Coordinated Care
Reductions to payments for graduate medical education (GME)	Reductions in Medicare funding for indirect and direct GME would jeopardize the ability of teaching hospitals to train the next generation of physicians and limit the ability of teaching hospitals to offer state-of-the-art clinical and educational experiences. AHA also urges Congress to eliminate the 17-year freeze in the number of physician training positions Medicare funds by supporting the creation of at least 15,000 new resident positions (about a 15% increase in residency slots) as included in the *Resident Physician Shortage Reduction Act of 2013* (S. 577/H.R. 1180).	AHA Factsheet AHA Infographic AHA Alliance for Graduate Medical Education
Changes to the 340B Drug Pricing Program	The 340B program is essential to helping safety-net providers stretch limited resources to better serve their communities. We support the continuation of this essental program, which saves money for providers and state and federal governments. The AHA supports program integrity efforts but will continue to oppose efforts to scale back this program.	AHA Factsheet AHA Infographic AHA Advocacy AHA Alliance for the 340B Drug Pricing Program

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Area of Vulnerability	AHA Position	Resources
Reductions in payments to hospitals for assistance to low-income Medicare beneficiaries (bad debt)	The Medicare program already pays less than the cost of providing care to Medicare beneficiaries. Reductions exacerbate this problem, especially for those hospitals that serve many low-income beneficiaries. Cutting reimbursement to hospitals for assistance to cover the debts of low-income Medicare beneficiaries while still paying less than the cost of care to Medicare beneficiaries is unfair.	AHA Factsheet
Changes to the critical access hospital program)	Congress and the administration have called for reduced CAH payments and the elimination of CAH designation based on mileage between CAHs and other hospitals. These proposals are misguided and demonstrate an unfortunate lack of understanding of how health care is delivered in rural America. These hospitals are the primary source of health care for the uninsured and underinsured and provide vital resources in times of emergencies. Many facilities may be forced to close and patients could lose their access to essential medical services if the program is altered.	AHA Factsheet AHA Infographic AHA Alliance for Rural Hospitals
Restrictions on Medicaid provider assessments	Provider assessment cuts are just another name for Medicaid cuts and harm the millions of children, poor and disabled Americans who rely upon this vital program. Medicaid, on average, covers only 89 cents of every dollar spent treating Medicaid patients. Further cuts to hospital funding would put enormous pressure on already stretched state budgets and could jeopardize this essential health care safety-net program.	AHA Factsheet AHA Alliance for Provider Assessments