American Hospital Association®

2015 ANNUAL MEETING | Advocacy Messages

Your Mission on Capitol Hill:

Use this opportunity to share with your legislators and their staffs how your organization is transforming care in your community. And stress with them that, to continue this process, **America's hospitals need three things:**

1. Relief Hospitals need a reprieve from onerous, duplicative and overzealous auditors and poorly constructed regulations that are diverting precious resources from patient care.

2. Reform The health care landscape is changing; laws and regulations must keep pace in order to encourage rather than inhibit transformation.

3. Resources Hospitals need stable and predictable reimbursement as they continue to transform and improve care for patients.

1. Relief

Hospitals need a reprieve from onerous, duplicative, over-zealous auditors and poorly constructed regulations that are diverting precious resources from patient care and drowning hospitals in unnecessary paperwork.

AMERICA'S HOSPITALS need relief from:

- Overzealous recovery audit contractors (RACs) that are wasting resources by inundating hospitals with requests for records, requiring specialized staff to handle the heavy workload, and flooding the government appeals process with denials that are overturned more than two-thirds of the time. The AHA supports legislation to make significant, fundamental changes to improve the program's efficiency and fairness.
- Onerous Centers for Medicare & Medicaid Services (CMS) rules that threaten care in rural communities. The AHA supports the Critical Access Hospital (CAH) Relief Act (H.R. 169/S. 258), which would remove the 96-hour physician certification requirement as a condition of payment for CAHs, and the Protecting Access to Rural Therapy Services Act (H.R. 1611/S. 257), which would adopt a default standard of "general supervision" (rather than "direct supervision") for outpatient therapeutic services and hold hospitals and CAHs harmless from civil or criminal action regarding CMS's retroactive reinterpretation of the standard.
- Unfair Medicare penalties that punish hospitals for factors outside of their control. The AHA supports the Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2015 (H.R. 1343/S. 688), which would adjust the Medicare Hospital Readmissions Reduction Program (HRRP) to account for certain sociodemographic factors that can increase the risk of a patient's readmission, ensuring that hospitals are not unfairly penalized.

2. Reform

The health care landscape is changing. To better serve their patients and communities, hospitals are strengthening ties to each other and physicians in response to new global and fixed payment models, incentives for improved quality and efficiency, implementation of electronic medical records systems and greater coordination across the health care continuum. Some of this realignment involves mergers and acquisitions, while new partnership models also are being fostered. However, laws and regulations have not kept pace and, in fact, threaten to hinder further progress.

AMERICA'S HOSPITALS support the following steps to help support the transformation of the health care delivery system:

- Re-introduction and passage of the Standard Merger and Acquisition Reviews Through Equal Rules (SMARTER) Act;
- Creating an anti-kickback safe harbor for clinical integration programs; and
- Refocusing the "Stark" law on its original intent – regulating self-referral to physician-owned entities.

In the recent Medicare Access and CHIP Reauthorization Act of 2015, Congress acknowledged the need for changes to the Civil Monetary Penalty law to remove impediments to improving care for patients and remedy the government's problematic interpretation of the law. The AHA advocated for this change and urges Congress to take the steps outlined above to further reduce the barriers to clinical integration to improve care for patients.

3. Resources

Every time Congress grapples with a fiscal crisis, payments for hospital care are at risk. The upcoming expiration of the debt ceiling, the prospect of budget reconciliation and other emerging crises heighten this risk. But hospitals need stable and predictable reimbursement as they continue to transform and improve care. Hospitals offer a lifeline to our nation's most vulnerable populations—the uninsured, the poor, the elderly and the disabled. But mounting cuts, the huge expenses associated with the upgrading of hospital IT systems and delays in coverage related to the Supreme Court's decision on Medicaid expansion are threatening hospitals' ability to continue to provide the essential services on which patients rely. This comes despite the fact that hospitals are controlling cost growth and reducing spending.

AMERICA'S HOSPITALS urge Congress to reject further cuts to funding for hospital care and support real solutions as Congress looks for ways to control spending. **Specifically, we urge Congress to reject:**

- Reductions to payments for hospital outpatient care (so called "site-neutral" cuts);
- Policies to equalize payments between inpatient rehabilitation facilities and skilled-nursing facilities for certain services;
- Reductions in payments to hospitals for assistance to low-income Medicare beneficiaries (bad debt);
- Reductions to payments for graduate medical education;
- Restrictions on Medicaid provider assessments;
- Reductions to rural hospital programs, including CAHs;
- Reductions to funding for hospital preparedness and response;
- Changes to restrictions on physician self-referral to physician-owned hospitals; and
- Harmful restrictions on the 340B Drug Pricing Program.

Fast Facts

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Total Number of Community Hospitals: 4,974

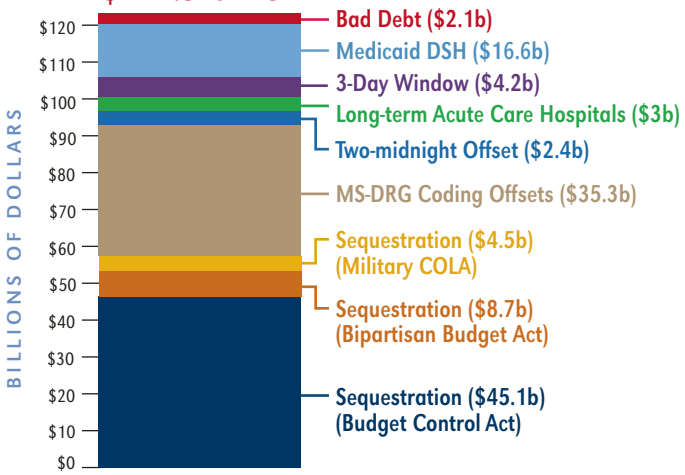
Total Number of Hospital Employees: 5.6 million

Every day, AMERICA'S HOSPITALS:

- treat **366,000** people in their emergency departments
- provide care for **1.5 million** other outpatients
- perform nearly **73,000** surgeries
- admit **92,000** patients
- deliver nearly **10,000** babies

From 2010 to 2014 alone, Medicare and Medicaid payments for hospital services were slashed by:

$121.9 billion



Those cuts came on top of a large uncompensated care burden and chronic underpayment from federal health programs:

- **In 2013**, hospitals provided more than **$46 billion** in uncompensated care.
- **Underpayment** by Medicare and Medicaid in 2013 to U.S. hospitals was **$51 billion**:
  - Medicare reimbursed **88 cents** for every dollar hospitals spent caring for these patients.
  - Medicaid reimbursed **90 cents** for every dollar hospitals spent caring for these patients.

The SMARTER Act

- Introduced last year in the House, the SMARTER Act would ensure that both antitrust agencies—the Federal Trade Commission (FTC) and the Department of Justice's Antitrust Division—have to prove their case before a neutral judge in the federal courts and not just internal proceedings in which the agency has a decided advantage. The bill, expected to be reintroduced this year, would:
  - Prohibit FTC from pursuing administrative litigation for transactions reported to the agency.
  - Apply the same legal standard to both federal antitrust agencies when they seek a preliminary injunction in federal court to challenge a merger.

Creating an Anti-kickback Safe Harbor

- The anti-kickback law has been stretched to cover any financial relationship between hospitals and doctors. In acknowledgement that there are cases where the statute thwarts good medical practices, Congress has periodically created "safe harbors" to protect those practices. Congress should create a safe harbor for clinical integration programs to allow all types of hospitals to participate, establish core requirements to ensure the program's protection from anti-kickback charges, and allow flexibility in meeting those requirements so the programs can achieve their health goals.

Refocusing the Stark Law on its Original Intent

- From its original intent of barring physician self-referral, the Stark law has been interpreted to prohibit hospitals from making payments to physicians that are tied to achievements in quality and efficiency—rather, payments must be for hours worked only. Congress should return the law to its original focus by removing compensation arrangements from the definition of "financial relationships" subject to the law.

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RAC Facts

- The RAC program has incentivized private Medicare contractors to deny as many high-dollar hospital claims as possible for financial gain. RACs receive a contingency fee of 9–12.5% for each claim denied.
- Hospitals appeal 49% of their RAC denials and win 72% of the time at the third level of appeal, according to the Health and Human Services' Office of Inspector General. But the appeals process also is heavily backlogged, taking up to three years for a claim to work its way through the system. Yet hospitals are allowed only one year to rebill any claim.
- Hospitals are committed to doing the right thing the first time, and are engaged in a number of efforts to ensure accurate coding and billing, making large investments in personnel, software and compliance programs.

Rural Health Facts

The nation's nearly 2,000 rural community hospitals frequently serve as an anchor for their region's health-related services, providing the structural and financial backbone for physician practice groups, health clinics and post-acute and long-term care services. In addition, these hospitals often provide essential, related services such as social work and other types of community outreach. Rural hospitals have additional challenges due to their often remote geographic location, small size, limited workforce, and constrained financial resources. CMS's 96-hour and direct supervision policies are unnecessary, onerous and could force these hospitals to limit hours and services provided.

Readmissions Facts

Research demonstrates that readmissions are higher in communities that are economically disadvantaged. The Medicare Payment Advisory Commission concurs that changes need to be made to the readmissions policy, urging CMS to recognize that sociodemographic factors affect the likelihood that a patient will be readmitted. The AHA also urges CMS to exclude readmissions unrelated to the initial reason for admission, as required by law. CMS has not fully implemented this policy.

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