



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) 2011 will be negative 7.0 percent – the ninth consecutive year of negative margins.

At the same time, hospitals face enormous changes associated with the *Patient Protection and 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 need adequate Medicare payment to ensure that patients and communities receive the care they expect and need.

AHA View

The AHA's 2011 advocacy agenda focuses on ensuring hospitals have the resources they need to provide high-quality care and meet the needs of their communities. For hospitals participating in Medicare, we are:

- Advocating for adequate Medicare payments, including a lower documentation and coding offset;
- Encouraging Congress to shore up payments for hospitals that train the physicians of the future;
- Working to extend expiring Medicare provisions; and
- Improving Medicare payments to rural hospitals.

Budget Cuts. In February, President Obama released a budget outline for FY 2012. The budget does not contain cuts to hospitals in the Medicare program for FY 2012. However, hospital services for people in need are being cut aggressively at the state and local levels while Medicare continues to pay hospitals less than the cost of providing services. **The AHA continues to work with the Administration and Congress to avoid further reductions while strengthening health care in America.**

Inpatient PPS Rule. The FY 2012 inpatient prospective payment system (PPS) proposed rule will continue efforts by the Centers for Medicare & Medicaid Services (CMS) to 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 has led to coding and classification changes that increased aggregate hospital payments without a corresponding increase in actual patient severity of illness.

For this reason, and to offset these payment increases, in the FY 2008 inpatient PPS final rule, the agency established a prospective documentation and coding adjustment of negative 1.2 percent for FY 2008, and negative 1.8 percent for FYs 2009 and 2010. Congress lowered this prospective adjustment to negative 0.6 percent in FY 2008 and negative 0.9 percent in FY 2009. No reductions were made in FY 2010; but in the FY 2011 inpatient PPS rule, CMS made a documentation and coding adjustment of negative 2.9 percent.

CMS continues to have authority to make additional cuts to hospital payments. The agency will discuss additional cuts in the FY 2012 proposed rule. The AHA expects that, at the very least, CMS will propose to maintain the 2.9 percent cut from FY 2011 to recoup the remainder of the alleged payment increases from FYs 2008 and 2009 that it said were above the negative adjustments it had already implemented. **The AHA continues to assert that CMS has used a flawed methodology and is overstating the effect of the documentation and coding change. The AHA continues its work with the Administration and Congress to ensure that CMS does not go beyond its charge of ensuring budget-neutral implementation of MS-DRGs.**

Value-based Purchasing (VBP). The AHA supports pay-for-performance programs that reward providers with payment incentives for demonstrating excellence in patient safety and effective care. The AHA worked with Congress to establish a hospital VBP program in the ACA that was budget neutral, resulting in no aggregate reduction in payments. The program also is consistent with many of the AHA's principles on pay-for-performance. CMS released a proposed rule in early January to implement the VBP program. The AHA supports the general direction of CMS' proposed rule but expressed serious concerns about the following specific proposals: the inclusion of hospital-acquired conditions in the VBP program, the weighting of the patient experiences of care survey data, and the required minimum number of patient cases to participate in the program. **The AHA encouraged CMS to address these concerns in the VBP final rule, which is expected later this spring.**

Self Referral to Physician-owned Hospitals. The ACA placed restrictions on physician self-referral to hospitals in which they have an ownership interest and limited expansion of those existing specialty hospitals that were grandfathered in the law. The AHA strongly supports these restrictions and successfully pushed for their inclusion in the ACA. However, many physician-owned hospitals have pushed for the repeal of these important restrictions. Recently, Reps. Sam Johnson (R-TX) and Doc Hastings (R-WA) each introduced legislation to repeal new limits on physician referral to hospitals in which they have an ownership interest. H.R. 1186 would repeal the ACA moratorium on self-referral to physician-owned hospitals formed after December 31, 2010, while H.R. 1159 would repeal both the moratorium and the requirement that physicians disclose their ownership

interest in hospitals to patients. **The AHA opposes both bills and urges Congress to maintain the restrictions of physician self-referral that were included in the ACA.**

Physician Supervision of Hospital Outpatient Therapeutic Services. In the calendar years (CYs) 2009-2011 outpatient prospective payment system (OPPS) rules, CMS mandated new requirements for “direct supervision” of outpatient therapeutic services. For 2011, CMS made changes to its policy, several of which are consistent with AHA recommendations.

Extension of Enforcement Delay. As the AHA requested, CMS extended for an additional year – through CY 2011 – its decision not to enforce the direct supervision policy for therapeutic services provided in critical access hospitals (CAHs). CMS also expanded this enforcement delay to include rural hospitals with 100 or fewer beds (those eligible for OPPS hold harmless payments).

Revised Definition of “Direct Supervision.” Consistent with AHA’s recommendations, CMS revised the definition of direct supervision for all hospital and CAH outpatient services to remove all references to the physical boundaries within which the supervising physician or non-physician practitioner (NPP) must be located. The revised definition requires only that the supervising physician or NPP be “immediately available to furnish assistance and direction throughout the performance of the procedure.”

Two-tiered Supervision Approach for Certain Services. CMS created a two-tiered approach to supervision for 16 specified hospital outpatient therapeutic services, identified as “nonsurgical extended duration therapeutic services.” For these services, direct supervision is required only for the “initiation” of the service. Once the supervising physician or NPP deems the patient medically stable, the remainder of the service requires only general supervision.

Process for Independent Review of Alternate Supervision Levels. CMS agreed with the AHA and others about the need for independent consideration of the most appropriate supervision level for individual therapeutic services. Therefore, in its CY 2012 OPPS proposed rule, the agency plans to propose an independent review process that will allow for an assessment of the appropriate supervision levels for individual hospital outpatient therapeutic services.

While the AHA appreciates CMS’ efforts to make the requirements more flexible, we continue to be concerned that, faced with shortages of health care professionals, particularly in rural areas, hospitals and CAHs will have difficulty implementing these requirements, and timely access to services will be reduced. CMS’ decision to extend and expand its enforcement delay is helpful for CAHs and small rural hospitals. However, those hospitals not included under the enforcement delay remain subject to enforcement action around the onerous policy. We continue to

disagree with CMS' repeated assertion that it has required direct supervision of outpatient therapeutic services since 2001.

The AHA continues to work with CMS and Congress to make more fundamental changes to the OPPTS supervision policy. A workable solution would:

- Adopt a default standard of “general supervision” for outpatient therapeutic services;
- Establish a reasonable exceptions process to identify specific procedures that should be subject to the two-tiered or direct supervision levels. We will work to ensure that the independent review panel identified by CMS includes adequate representation of physicians, nurses and other clinicians practicing in rural (including CAHs) and urban hospitals and that the exceptions process is subject to notice and comment through a public rulemaking process;
- 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; and
- Prohibit enforcement of CMS' retroactive reinterpretation that the “direct supervision” requirements applied to services furnished since January 1, 2001.

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 the value of the enhanced services beneficiaries receive in teaching hospitals, as well as its responsibility for funding its share of the direct and indirect costs of training medical professionals. The AHA is pleased that Congress and the Administration did not call for reductions in Medicare direct or indirect medical education payments to teaching hospitals in either the ACA or the President's 2012 budget. In addition, while the AHA supports the provision in the ACA that redistributes unused residency training slots as a way to encourage increased training of primary care physicians and general surgeons, there are still insufficient numbers of residency training positions funded by the Medicare program. **The AHA will continue to push Congress for additional Medicare-supported, physician-training positions, which will be critical to expanding the physician workforce that is needed to provide care for the newly insured. The AHA also is working to maintain existing funding for graduate medical education conducted in children's hospitals (Refer to “Annual Appropriations” issue paper).**

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 60 percent still lose money treating Medicare patients. **The AHA is pleased that Congress provided relief on certain issues as part of the *Medicare and Medicaid Extenders Act of 2010*. In 2011, we continue to work with Congress to provide small, rural hospitals with adequate reimbursement, including extension of expiring rural provisions.** For more information, see the AHA's issue paper "Rural or Small Hospitals."

Cancer Hospitals Adjustment. Section 3138 of the ACA required CMS to conduct a study to determine if dedicated cancer hospitals' costs were greater than the costs of other hospitals paid under the OPDS. If the study showed that cancer hospitals' costs were greater, CMS must provide for an appropriate adjustment to reflect these higher costs. The adjustment is required to be budget neutral.

The AHA supports a revision to Section 3138 that would protect cancer hospitals' current hold harmless payments while also providing a more appropriate adjustment that would recognize their relatively higher outpatient costs for treating cancer by limiting their loss per unit to no more than the losses experienced by other hospitals for treating all diseases. This approach addresses the inadequate outpatient payments for dedicated cancer hospitals, while minimizing the impact on all other hospitals.

POST-ACUTE CARE

Long-Term Acute Care Hospitals (LTACH). The AHA is leading a process to develop patient and facility criteria to distinguish the role of LTACHs in the continuum of health providers and to replace CMS' 25% LTACH Rule. The criteria development process includes representatives from general acute hospitals, for-profit, not-for-profit, freestanding and hospital-within-hospital LTACHs, and inpatient rehabilitation hospitals. The AHA's proposal includes new inpatient criteria for screenings on admissions by a physician, programmatic, personnel and operational facility criteria, and a retrospective criterion ensuring that 70 percent of patients have a high level of complexity. The AHA's proposal also would eliminate CMS' LTACH 25% Rule, very short stay outlier, and one-time budget neutrality policies that were implemented, in part, due to the absence of LTACH criteria. **The AHA will urge Congress to establish patient and facility criteria to distinguish LTACHs from other care settings and eliminate the 25% Rule.**

Post-acute Value-based Purchasing. In 2011, the AHA will contribute to CMS processes required under the ACA to develop quality measures for inpatient rehabilitation facilities (IRF) and LTACHs. In addition, the AHA will provide input to CMS' efforts to advance the current home health (HH) and skilled nursing facility (SNF) pay-for-reporting programs toward pay-for-performance, as mandated by the ACA.

CMS' Post-Acute Care Payment Reform Demonstration (PAC-PRD).

Through this demonstration, CMS is developing a common patient assessment

instrument to assess patients being discharged from a general acute hospital to help identify the level and type of post-acute care needed following discharge. This demonstration also is collecting comparative data on the scope and volume of treatments and related Medicare payments for services provided in the four post-acute settings – LTACHs, IRFs, SNFs and HH. The resulting patient assessment tool is widely expected to replace the inconsistent tools currently used in these four settings, and to be a cornerstone for future delivery system reforms such as accountable care organizations and payment bundling. As CMS plans to report PAC-PRD findings to Congress in June 2011, the AHA will work with members participating in this demonstration to examine the implementation issues hospitals experienced in this demonstration. The AHA will work to ensure that the findings accurately reflect hospital experiences so that any future uses of the tool will be improved.