



Arizona Hospital and Healthcare Association

The 2009 Budget Debate: Protect Medicare and Medicaid Patients

As the 2009 budget debate continues, the Arizona Hospital and Healthcare Association (AzHHA) urges the U.S. Senate and House of Representatives to protect Medicare and Medicaid in the budget resolution that will be adopted later this spring. We are encouraged that the Congress appears poised to pass a budget blueprint that includes no direct cuts to Medicare and Medicaid, but we remain concerned that spending offsets leave the door open to cuts later in the year. AzHHA urges Arizona's congressional delegation to protect Medicare and Medicaid patients—and the hospitals that take care of them—during the reconciliation process.

Proposed Medicare Cuts Threaten Hospitals

President Bush has proposed a fiscal year 2009 budget that would cut an unprecedented \$182 billion from Medicare over five years, \$135 billion of which would come from hospitals. The president's proposed Medicare cuts would reduce payments to Arizona hospitals by more than \$1.1 billion over five years. Nationally, Medicare pays hospitals only 91 cents for every dollar of care they provide to a Medicare patient. Arizona hospitals receive just 94 cents on the dollar for Medicare services. At a time when America's economy is faltering and demand for hospital services is rising, cuts of the magnitude the president proposes would jeopardize hospitals' ability to provide critical services to all patients.

The president's budget raises several policy issues that warrant congressional attention and debate. Toward that end, AzHHA urges Arizona's congressional delegation to carefully consider the following options and guiding principles:

Repeal the "45 Percent Trigger." The president's proposed Medicare cuts are, in part, a response to the so-called "45 percent trigger" included in the Medicare Modernization Act (MMA) of 2003. Under the MMA, Medicare's trustees estimate the ratio by which Medicare program expenditures are expected to exceed dedicated revenue from the general treasury to support Medicare. If the trustees project, for two consecutive years, that the ratio will exceed 45 percent within seven years, the trustees must issue a determination of "excess general revenue funding." That determination triggers a process by which the president and Congress must respond to the warning. In their 2007 annual report, the Medicare trustees issued the first Medicare funding warning when, for the second year in a row, they projected that the 45 percent threshold would be exceeded within seven years, specifically by 2013. As a result, within 15 days of submitting his budget proposal for fiscal year 2009, the president must submit legislation to Congress responding to the warning. Thus, the reductions in the president's budget recommendation are at least in part a response to the 45 percent

trigger. Importantly, the 45 percent trigger does not automatically result in spending reductions to Medicare; however, Congress must pass and the president must sign legislation to address the situation.

AzHHA joins the American Hospital Association (AHA) in opposing the 45 percent trigger because it is an arbitrary mechanism to reduce Medicare funding at a time when increasing numbers of patients rely on the program for their care. The Medicare provisions of the House-passed Child Health and Medicare Protection Act of 2007 (CHAMP) included a provision that would repeal the trigger. **AzHHA and AHA continue to support repealing the 45 percent trigger.**

Ensure Value-Based Purchasing Programs Focus on Positive Incentives. The president's budget calls for establishment of a hospital value-based purchasing program, which would result in a \$1.7 billion cut to Medicare hospital payments over five years. Both private and public payors are considering and testing the use of incentive payments—sometimes called “pay-for-performance” approaches—to reward hospitals for their performance. Hospital leaders in Arizona and across the nation believe the concept of rewarding excellence through payment may hold merit as a future system of payment for hospital services. However, many of the pay-for-performance approaches that have been implemented to date have resulted in payment penalties, inequities, and other serious consequences for hospitals and the patients they serve.

Arizona hospitals are committed to continuously improving the quality and safety of healthcare services provided to patients. As Congress considers the proposed value-based purchasing program, AzHHA urges Arizona's congressional delegation to ensure that the approach is truly designed to incentivize quality improvement and not simply to make arbitrary payment cuts. Toward that end, AzHHA strongly supports the AHA's attached *Principles for Using Payment to Reward Performance*.

Ensure a Fair System for Identifying Serious Reportable or “Never” Events. The president also recommends elimination of Medicare payment for serious reportable events, sometimes called “never events,” and identifies a savings of \$190 million over five years associated with adoption of this policy. AzHHA joins the AHA in supporting the Institute of Medicine's recommendation that hospitals report errors and adverse events that occur during the delivery of healthcare services in a systematic way to enable hospitals to learn from their mistakes and work to prevent them in the future. The National Quality Forum's (NQF's) efforts to identify serious reportable events to facilitate reporting and public accountability represent a starting point to guide when regulatory and accrediting bodies should assist in ensuring appropriate actions are taken to improve patient safety.

It is important to note, however, that the NQF list of serious reportable events was never intended to be used to determine payment for care. The criteria have served well for determining whether an event should be *reported*; however, they do not translate well into a methodology for determining whether *payment* should be made or withheld. As Congress considers the president's proposed elimination of payment for

serious reportable events, AzHHA joins the AHA in offering the following five principles to guide the identification of such events for which payment might be withheld:

- **The error or event must be preventable.** A hospital should not be held accountable for something the hospital could not reasonably have prevented from occurring. A root cause analysis may be required to determine preventability.
- **The error or event must be within the hospital's control.** Hospitals should not be held accountable for errors that may have occurred, for example, in the manufacture of drugs, devices or equipment, well before the materials reached a hospital's doors. A root cause analysis may be required to determine the source of the error.
- **The error or event must be the result of a mistake made in the hospital.** The event must clearly and unambiguously be the result of a mistake made, hospital procedures not followed, and not something that could otherwise occur.
- **The error or event must result in significant harm.** As did the NQF, the list of events should be limited to those that yield very serious results.
- **The error or event must be clearly and precisely defined in advance.** A greater level of specificity than included in the NQF list today is required for identifying events if those events would result in penalizing a hospital through non-payment. Current definitions are too ambiguous for such strict accountability.

Based on these principles, the NQF list would need to be modified for use in determining non-payment for specific serious reportable events. Moreover, any process for identifying non-payable events would necessitate some element of case-by-case review.

Finally, Congress must recognize that physicians play a critical role in improving patient safety. Hospitals should not be expected to bear the financial penalty solely on their own; physicians must also be incentivized to prevent medical errors.

Protect Access to Rehabilitation Services. AzHHA applauds Congress for protecting patients' access to inpatient rehabilitation services by passing legislation in 2007 that froze the so-called "75 percent" threshold at 60 percent. This rule requires that, to be reimbursed as an inpatient facility under Medicare, 75 percent of a rehabilitation facility's patients must be treated for a set of 13 specific conditions. However, that set of conditions has not been adequately updated to reflect modern medical rehabilitation

practices and advances. Therefore, the 60 percent threshold should be maintained at least until the Centers for Medicare and Medicaid Services (CMS) updates the set of conditions. The president has proposed reinstating the “75 percent rule” in his fiscal year 2009 budget, a move AzHHA urges Congress to reject.

AzHHA recognizes that many members of Congress are committed to cutting the federal deficit by 2012. We also understand that Congress must balance other critical needs, including funding to restore scheduled cuts in Medicare physician payments. While AzHHA strongly supports the physician payment fix, we join the AHA in urging Congress to recognize that, as millions of baby boomers prepare for retirement, hospitals must have critical resources necessary to meet the increased healthcare needs of an aging population. Recently, Congress’ independent, nonpartisan Medicare Payment Advisory Commission (MedPAC) voted to recommend to Congress that hospitals receive a full inflation update in 2009. We urge Arizona’s congressional delegation to support MedPAC’s recommendation and refrain from cutting Medicare in the 2009 budget.

Preserving Access to Care in Rural Arizona

More than 1.5 million people who live and work in rural Arizona depend on their community hospitals to be the primary access point for healthcare in their communities. In order to continue to meet their patients’ divergent needs, rural hospitals must receive adequate compensation. Recent changes in Medicare policy have left these safety net hospitals vulnerable on this front. **In order to protect these hospitals, AzHHA urges Congress to:**

- **Ensure critical access hospitals (CAHs) and the rural health centers (RHCs) they operate are appropriately reimbursed under Medicare Advantage.**
- **Restore cost-based reimbursement for lab services provided by CAHs regardless of where the specimen is collected.**
- **Allow CAHs to use an alternative bed limit methodology, one that is sensitive to seasonal fluctuations.**
- **Restore the five percent rural add-on for home health.**
- **Make hold-harmless payments permanent for all sole community hospitals (SCHs).**

Ensuring CAHs Receive Appropriate Reimbursement. There are currently 12 CAHs located in remote communities throughout rural Arizona. These hospitals, which are capped at 25 beds, are paid 101 percent of allowable costs for services provided to Medicare beneficiaries. Congress has recognized that this reimbursement structure is essential for maintaining the financial viability of these hospitals. Unfortunately, recent regulatory and legislative actions have resulted in CAHs receiving less than cost for many services.

The MMA created structural and economic incentives for Medicare Advantage (MA) managed care plans to enter the rural marketplace. However, no provisions were included to ensure that CAHs would receive cost-based reimbursement—as they do under traditional Medicare. It was assumed that CAHs would negotiate for cost-based reimbursement, at or above the current 101 percent level. If MA plans and CAHs could not reach agreement, CAHs could opt out of the plan’s network. This has turned out to be an unrealistic assumption.

- Many plans are not required to contract with hospitals. The most prevalent type of MA plan in rural areas, private fee-for-service plans, may “deem” providers as plan participants. Under this arrangement, MA plans pay CAHs based on interim costs with no requirement to “true up.” CAHs providing services to patients covered by these plans typically receive less than cost.
- Opting out is not a good answer in isolated communities. Because a CAH is the sole source of hospital services, it is not in the community’s best interest to opt out of a network. Unlike in an urban area where there are multiple providers, if a CAH opts out of a network, beneficiaries would have to travel many miles for hospital services.
- MA jeopardizes cost-based reimbursement for RHCs. A number of Arizona CAHs operate RHCs. These clinics compete with federally qualified health centers (FQHCs), which are guaranteed 101 percent of allowable costs under MA. The MMA of 2003 did not extend this guarantee to RHCs, although like FQHCs, they provide safety net services. In order to level the playing field and provide adequate coverage to rural Arizonans, RHCs should receive 101 percent of allowable costs.

We urge Arizona’s congressional delegation to support H.R. 2159 and S. 630, the Rural Health Services Preservation Act, which require MA organizations to pay for CAH and RHC services at a rate of at least 101 percent of allowable costs.

In October 2003, the Centers for Medicare and Medicaid Services (CMS) began requiring Medicare beneficiaries to be physically present in a CAH when a lab specimen is drawn in order for the hospital to receive cost-based reimbursement. Because lab services are limited in small rural communities and Medicare beneficiaries are not always able to travel far distances, many CAHs had been collecting specimens from outpatients off campus (e.g., at clinics, skilled nursing facilities, etc.). Under the 2003 regulation, CAHs have not received cost-based reimbursement for these needed services.

We urge Arizona’s congressional delegation to support S. 1277, the Critical Access to Clinical Lab Services Act, which restores cost-based reimbursement for referral lab services.

Retain the Integrity of the CAH Bed Limit, but Permit Flexibility for Seasonal Fluctuations. A CAH may operate no more than 25 beds at any time under current law. This cap makes it extremely difficult for CAHs to respond to seasonal

fluctuations, such as those that occur during winter flu months when visits soar. Without any flexibility in this bed limit, CAHs are often forced to transfer patients outside their communities. This is difficult for patients and families, and increases the overall cost of healthcare due to added transport costs. The situation is exacerbated when larger hospitals are overcapacity and unable to accept transfers.

We urge Arizona’s congressional delegation to support S. 1595, the Critical Access Hospital Flexibility Act, which would permit CAH s to meet the statutory CAH bed threshold with a 20-bed average daily census.

Provide Adequate Payment for Rural Home Health Services. Recognizing the higher cost of providing home health services in rural areas, Congress enacted a 10 percent rural add-on for home health services in the Benefits Improvement and Protection Act of 2000. This adjustment was extended at 5 percent in the MMA of 2003 and again in the Deficit Reduction Act of 2005, after which it expired at the end of 2006. Loss of the rural add-on has made it difficult for hospitals that provide home health services to retain staff at a competitive salary and has resulted in the reduction in services in some areas.

We urge Arizona’s congressional delegation to support reinstatement of the 5 percent rural add-on, which is included in S. 1605, the Rural Hospital and Provider Equity (R-HOPE) Act, and H.R. 2860, Health Care Access and Rural Equity (H-CARE) Act.

Making Hold-harmless Payments Permanent for all SCHs. Congress created the SCH program in the 1980s to ensure Medicare beneficiaries in isolated communities have access to necessary, quality healthcare services. Hospitals qualify for SCH status by demonstrating that, due to distance or geographic boundaries, they are the sole source of hospital services available in a wide geographic area. In Arizona, there are more than a dozen SCHs, serving communities as diverse as Yuma and Springerville.

Congress has long appreciated the vital role SCHs play in isolated communities and has sought to ensure their viability through special payment provisions. With implementation of the outpatient prospective payment (OPPS) system in 2000, Congress authorized hold-harmless payments to small rural SCHs for three years. These payments have allowed hospitals to receive the greater of established OPPS rates or hospital-specific cost-based rates. Recognizing the importance of these payments, Congress reauthorized them and extended them to all rural SCHs in the MMA of 2003.

However, there were two shortcomings to the hold-harmless protections in the MMA. First, due to budgetary constraints, Congress enacted these protections for only two years. Second, the protections applied only to rural SCHs. Urban SCHs, located in communities with greater than 50,000 persons (such as Yuma and Flagstaff), have not been eligible for these payments – even though they provide the same services and incur similar costs as rural SCHs.

We urge Arizona's congressional delegation to support H.R. 1177, the Sole Community Hospital Preservation Act, and S. 2381, Medicare Sole Community Hospital Preservation Act, which make permanent hold-harmless payments for all SCHs.

Proposed Medicaid Cuts Cripple Arizona's Physician Growth Strategy

Arizona's hospitals are also deeply concerned about provisions in the president's budget that reduce Medicaid spending by \$17 billion over five years, much of which could be implemented through administrative action without congressional input or oversight.

We are particularly alarmed that the administration seeks to eliminate Medicaid funding for graduate medical education (GME), which is the primary vehicle Arizona policymakers have identified to address our severe physician shortage. Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), estimates that this proposed cut would result in a total loss of \$45.9 million (\$30.1 million state funds and \$15.8 million federal funds) in fiscal year 2009.

Released in November 2006, *Part II of Arizona's Physician Workforce Study* revealed that, while the number of physicians practicing in Arizona has increased slightly in recent years, our physician workforce is not keeping pace with the growth in our population. With 219 physicians/100,000 population, Arizona remains well below the national average of 293/100,000. Funds for GME flow to Arizona's teaching hospitals through AHCCCS, and are used to pay the salaries of resident physicians and other direct costs associated with training physicians. Recognizing that physicians tend to practice in the states where they complete their residency training, Arizona's governor and Legislature in 2006 increased Arizona's investment in our physician workforce by appropriating a total of \$12 million in additional state and federal GME funds for residency programs. In 2007, acknowledging that the *Physician Workforce Study* found the most stark physician shortages in Arizona's rural communities, Arizona lawmakers appropriated an additional \$9 million in state and federal GME funds for rural hospital residency programs and urban programs that include rural rotations.

AzHHA applauds Congress for passing legislation in 2007 to prevent CMS from working on any rules to eliminate Medicaid GME funding, and we are encouraged that Congress appears poised to extend this moratorium in 2008. We urge Congress to maintain its longstanding commitment to GME and continue to recognize the critical role these funds play as teaching hospitals train the next generation of physicians and care for low-income patients.

Increase the Federal Medical Assistance Percentages

Arizona—like many states across the nation—is struggling to provide care to a burgeoning Medicaid population despite revenues that are declining due to the current economic downturn. Facing a \$1 billion deficit in the current fiscal year and a \$2 billion deficit in fiscal year 2009, Arizona's governor and lawmakers are currently considering dramatic cuts in state spending for programs that significantly affect

Arizona's hospitals. These proposed cuts total approximately \$91.1 million in state and federal funds that directly or indirectly affect hospitals in our state. As Congress considers elements of an additional economic stimulus package, AzHHA asks Arizona's congressional delegation to support including an FMAP increase to help prevent devastating cuts to community hospitals. **Toward that end, AzHHA joins the AHA in supporting H.R. 5268 and S. 2620, which would increase the FMAP by 2.95 percent from April 1, 2008 through June 30, 2009.**