Advocacy 2010

Keeping the Commitment

Kansas hospitals have a long and distinguished commitment of providing care for all who seek it, 24 hours a day; 7 days a week; 365 days a year. When a medical emergency hits, the focus must be on delivering the highest quality health care services available as quickly and efficiently as possible. As the new health reform law comes online, this will continue to be the priority for Kansas hospitals.

Beyond Health Reform

The debate over how health reform should be conducted will continue to be voiced for the foreseeable future. However, until Congress acts again, the recently passed *Patient Protection and Affordable Health Care Act (PPACHC)* is the law of the land and Kansas hospitals will need Congress' help in supporting those provisions that are good for Kansas, fixing those issues that can be made better, and eliminating those that simply make it impossible for our hospitals.

What KHA Members Said

KHA's recent round of Spring District Meetings afforded us an opportunity to meet with nearly 120 representatives from 90 hospitals. This spring's agenda was dedicated to the recently passed PPAHC. Not surprisingly, our members are both concerned and anxious over the scope and complexity of the legislation. Here is what they asked us to share with you:

- Kansas hospitals need our entire Congressional delegation to stay engaged and work together to make the necessary changes to the legislation;
- Kansas hospitals need our entire Congressional delegation to help resolve the stalemate over a permanent and equitable fix to Medicare's Physician Payment Schedule;
- Kansas hospitals need our entire Congressional delegation to push to have the section of the legislation that created the Independent Payment Advisory Board repealed;
- Kansas hospitals need our entire Congressional delegation to guard against any "unintended consequences" arising from the legislation;
- Kansas hospitals are uniformly concerned over the ability of our state to efficiently process and manage a significant increase in the number of Medicaid-eligible's;
- Kansas hospitals are uniformly concerned over the implementation of the requirements for Charitable Hospitals including the posting of all hospital charges, conducting a community needs assessment and reprogramming all their billing systems to accommodate new financial assistance mandates.
- Kansas hospitals are uniformly concerned over the overabundance of regulatory requirements required of the Secretary of Health and Human Services to write and implement. The Administrative burden associated with the compliance of these new rules and regulations will add considerably to the cost of providing care within our state's hospitals.

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Keeping the Commitment
Health Reform Key Issues

The passage of the *Patient Protection and Affordable Care Act* and the *Health Care and Education Reconciliation Acts of 2010* constitutes the largest changes to America's health care delivery system since the creation of Medicare and Medicaid in the mid-1960's. The Congressional Budget Office estimates that the new laws will expand coverage to 32 million individuals.

Coverage and Costs: The new law estimates that coverage will be expanded to 32 million new individuals through a combination of public programs and private-sector health insurance expansions by 2014. An important component of the expansion will be an increase in Medicaid eligibility for individuals and families with annual incomes below 133 percent of the prevailing Federal Poverty Guidelines. While the increase in coverage will be incremental over the next five to ten years, the market basket reductions called for in the legislative actually began on January 1 of this year. Disproportionate Share Hospital Payments are also being reduced significantly. Congress must monitor these "pay-for" provisions very closely to ensure providers are receiving the increase in coverage that is anticipated. Hospitals' operating margins are too close to the breaking point to have this provision too far off the mark.

340b Prescription Drug Program: The original Senate version of the health care legislation included both inpatient and outpatient drugs in the program's expansion to Critical Access, Sole Community, Rural Referral, Children's and Cancer hospitals. The *Health Care and Education Reconciliation Act* struck the inpatient provision thus eliminating a significant amount of savings and cost reductions hospitals could access. Not only that, both the Federal and State governments would benefit from the lower costs. Congress must work to add back in the inpatient provisions to the 340b program.

Key Delivery System Reforms: The law created several key delivery system reforms that are designed to better align provider incentives to improve care coordination and quality while at the same time reducing overall costs. It took steps toward paying for quality rather than volume of services. These reforms include a value-based purchasing system; voluntary pilot projects to test bundled Medicare payments for selected episodes of care; Accountable Care Organizations that can share in Medicare savings; and financial penalties for hospitals with "excessive" readmissions. While all of these have promise in the long run, the real test of their effectiveness will be in how the Centers for Medicare and Medicaid Services elects to implement these delivery reforms.

Physician Payment Issues: The Medicare physician payment formula is severely flawed and, in recent years, would have resulted in significant payment cuts for physicians without legislative intervention. The *PPACHC* reinstated provisions that expired on Dec. 31, 2009 and increased the geographic practice cost indices in some localities. Kansas physicians can expect up to a 4.6 percent increase in payments as a result. However, the "sustainable growth rate" (SGR) formula that was created with the Balanced Budget Act has not been addressed. As of January 1, physicians were scheduled to receive a 21 percent cut in Medicare payments. KHA supports a permanent, long-term replacement of the flawed physician payment formula. The formula fix should be accomplished in a non budget-neutral manner so that it does not result in reduced payments to other providers.

Keeping the Commitment

Rural Issues

Kansas leads the nation in the number of Critical Access Hospitals at 83. Additionally, another 22 hospitals paid under Medicare's Prospective Payment System are located in rural communities. Rural hospitals are important to Kansans. But because of their small size, modest assets and financial reserves, and higher percentages of Medicare and Medicaid patients, rural hospitals depend on government reimbursement more so than other hospitals. While improving over the past several years, over 60 percent of rural hospitals lose money treating Medicare patients. Many rural hospitals are too large to qualify for CAH status, but too small to absorb the financial risk associated with Medicare's Prospective Payment Systems. Also, the existing special rural payment programs – CAH, Sole Community, Medicare-dependent Hospital and Rural Referral Center – need to be updated.

KHA members were pleased that Congress included the following legislative relief as part of the *PPACA:*

- Extended the outpatient hold-harmless payments for certain hospitals in rural areas;
- Created a payment adjustment for low-volume hospitals;
- Extended the Medicare rural Hospital Flexibility Program through 2012;
- Ensured that CAHs are paid 101 of costs for all outpatient services regardless of the billing methods elected;
- Extended the Medicare-dependent Hospital program for one year;
- Extended reasonable cost reimbursement for laboratory services in small rural hospitals;
- Reinstated a 3 percent rural home health add-on payment; and
- Provided access to 340b drug discount program for outpatient services for CAH, SCH and RRC hospitals.

Congress Must Continue to Support Rural Hospitals: While the *PPACA* provided a number of benefits for rural hospitals, the fundamental need for continued support to these vulnerable providers has not changed and only looks to worsen over the next decade. Congress must consider:

- Providing small, rural hospitals with cost-based reimbursement for all outpatient laboratory and ambulance services without regard to artificial mileage barriers;
- Ensure that CAHs are paid at least 101 percent of costs by Medicare Advantage plans;
- Ensure CAHs receive cost-based reimbursement for certified nurse anesthetist services; and
- Remove all of the unreasonable restrictions on CAHs' ability to rebuild aging and out-of-date facilities that would be too costly to remodel.

Physician Supervision of Hospital Outpatient Therapeutic Services: The Delegation's unified letter to HHS Secretary Sebelius was instrumental in her instructing CMS to cease enforcement of their unreasonable rules for CAHs for the balance of 2010. However, CMS did not definitively change the policy to reflect how health care services are delivered in rural communities. In our conversations with CMS officials, they continue to portray the policy shift as a mere "clarification and restatement" of requirements that have been in place since 2001. As a result, hospitals find themselves at risk for unwarranted enforcement actions after this year. Congress must instruct CMS to make a more fundamental and reasonable change to the physician supervision policy.

Keeping the Commitment
Health Information Technology

The HITECH Act included in ARRA requires all hospitals and physicians to meet extensive benchmarks illustrating that they are meaningful users of Electronic Health Records and can exchange data with other providers, patients and state and federal governments. To provide the financial incentive needed for EHR adoption, the *American Recovery and Reinvestment Act* authorized Medicare and Medicaid EHR Incentive Programs beginning in 2011. Incentives are granted after a hospital has expended the resources to purchase and implement the technology as well as the significant human resources for technical support, to change traditional processes and train staff. If providers have not met these benchmarks, penalties begin in 2016.

Meaningful Use: CMS released a proposed rule which articulated their criteria in order to meet the requirement of "meaningful use." Hospitals and physicians must meet their criteria in order to secure the incentive payments authorized by the ARRA. While hospitals have made great strides in implementing health IT, a January 2010 survey found that less than one percent reporting could meet all 23 of CMS' standards. Because of the high costs and potential for disruption of care, many Kansas hospitals cannot afford to implement a comprehensive EHR within the timeframes established in the ARRA.

KHA believes that the meaningful use criteria and timeline proposed by CMS are unrealistic and far exceed Congress' intent. KHA supports an alternative approach that recognizes the efforts currently underway in hospitals, provides operational and strategic flexibility, and ultimately results in the shared national vision of an e-enabled health care system.

For hospitals to achieve effective use of health IT systems, it is essential that IT vendors produce systems capable of fulfilling the requirements of meaningful use as well. Certification policy should actively reinforce a clear distinction between the responsibilities of vendors and hospitals. Lastly, the time frames required in the ARRA are too aggressive for the majority of hospitals to meet. KHA believes that a "grandfathering" policy for certification is needed to ensure the EHR incentive payments can begin in 2011 as Congress intended.

Physicians in Rural Health Clinics: The statutory language in the HITECH Act established the procedure for determining the amount of incentive funds hospitals and eligible providers would receive when "meaningful use" was achieved. That language makes it impossible for physicians in Rural Health Clinics to actually receive incentives. Even the Eligible Provider "fix" included in the Jobs Bill, does not address this hole in the program.

Unique billing procedures required by CMS for provider-based RHCs do not use the codes required by the HITECH Act to document Medicare charges which are the basis for the incentive. Kansas has over 180 Rural Health Clinics that will be affected by this hole in the law. While RHC-based physicians do qualify for the Medicaid incentive, the majority of Kansas rural areas served by these physicians do not provide the volume of Medicaid necessary to qualify. Consequently, much of the expected benefit of EHR implementation statewide will likely not be met as a large number of rural physicians are not incentivized to participate. We need your help in correcting this oversight.