

ILLINOIS HOSPITAL ASSOCIATION 2010 FEDERAL ADVOCACY AGENDA



HEALTH CARE IN AN ERA OF REFORM

After more than a year of debate, Congress and the President have enacted sweeping health reform legislation designed to bring affordable health insurance coverage to 32 million previously uninsured Americans, improve the availability and security of coverage for those who already have it, and begin to control the escalating costs of health care. Although the process for achieving reform was difficult and contentious, and the final legislation is not perfect, the status quo was unsustainable. The Patient Protection and Affordable Care Act (P.L. 111-148) is an historic step forward in advancing health care delivery in this country, and provides us with a solid foundation to build on for the future. We are grateful to our members of Congress who supported health care reform and to all members who invigorated and contributed to the national debate and raised national awareness of this critical issue.

Working
together to
fulfill the
promise of
health care
reform



ENSURING ACCESS DURING HARD TIMES

The passage of health reform legislation is a significant step toward universal health care coverage. However, we must ensure that the Illinois Medicaid program remains viable during this period of high unemployment and economic hardship. Extension of the increased Federal Medical Assistance Percentage (FMAP) matching rate is an immediate priority for Illinois and is necessary to help the Illinois Medicaid program weather the added pressures of a serious economic downturn and increased numbers of Medicaid patients. The current temporary FMAP increase, part of the American Recovery and Reinvestment Act, raised Illinois' federal Medicaid matching rate from 50% to nearly 62% through Dec. 31, 2010. We urge Congress to pass H.R. 4213, legislation to extend the temporary FMAP increase through June 2011. **This action would carry the state through its fiscal year and mean approximately \$700 million in additional Medicaid funding for Illinois.**

Longer term, it is important for Illinois to have a permanent increase in the state's FMAP rate. Without the rate increase, Illinois is at the lowest federal matching rate (50%), even though it provides 4.1% of the nation's Medicaid services while receiving 3.3% of total Medicaid funding – a gap that costs the state more than \$1 billion annually.

While several coverage expansion provisions will take effect in 2010, hospitals are likely to continue seeing substantial numbers of uninsured patients until additional coverage expansions become effective in 2014. The economy is still in a serious contraction, with Illinois facing a massive budget deficit and many people suffering the consequences of the economic downturn.

Medicaid payments to hospitals not only strengthen our health care safety net but also create immediate economic stimulus – generating new rounds of spending (and tax revenues) as well as job creation and retention throughout the local and state economies. Each \$1 in Illinois Medicaid spending generates another \$2.50 in further economic activity. Illinois hospitals are among the top three employers in nearly half of the state's counties, together employing nearly a quarter of a million people. Through **a long-term increase in the FMAP rate**, the additional Medicaid dollars will help keep the Illinois health care safety net intact and will help hospitals remain vital economic engines for local and state economies.

Underlying the premise of the health reform legislation is the notion of the shared responsibility that makes this legislation and its expansion of health insurance coverage possible. However, the level of the Medicare and Medicaid reimbursement reductions, including disproportionate share – over \$8 billion over ten years for Illinois – is significant and could weaken the sustainability of the Illinois health care system and impede efforts to successfully implement reform. IHA will urge reducing hospital and health system cuts while ensuring appropriate delivery system reform.

IHA will work closely with the Illinois Congressional delegation to carefully monitor what the impact of the Medicare and Medicaid reductions and other policies in the legislation have on Illinois providers as they pursue their mission to deliver high quality and accessible care to Illinois communities.

PRESERVING THE PARTNERSHIP – HOSPITALS AND GOVERNMENT

Passage of comprehensive health care reform has been compared to the creation of the Medicare program in 1965. It builds on the longstanding partnership between hospitals and the Government to provide health care to communities throughout this country. The implementation of the reform bill will be phased in over the next several years; at the same time that there will be an influx of baby boomers into the Medicare program. These newly-eligible Medicare beneficiaries will place additional stress on the program. It is for these reasons that IHA presents recommendations that will help sustain the Medicare program through its upcoming period of significant growth and strengthen the hospital-government partnership.

Hospital Readmissions

The health care reform legislation calls for readmission-related payment cuts to hospitals starting in federal fiscal year (FFY) 2013 that will total \$7 billion over 10 years. Specifically, this policy would reduce DRG payments for Prospective Payment System hospitals with higher than anticipated readmission rates. The policy would apply to readmissions within a 30-day window of the original admission.

Of particular concern to hospitals is the fact that this policy does not differentiate between unplanned readmissions related to the initial admission and all other readmissions. IHA acknowledges that hospitals should not be financially rewarded for readmissions that should have been avoided. **However, neither should hospitals be penalized for readmissions over which they have no control. A policy to reduce readmissions should focus on avoidable and unplanned hospital readmissions related to the original admission.**

340B Drug Discount Program

IHA appreciates the extension of the 340B drug discount program for outpatient pharmaceutical services to children's hospitals, cancer hospitals and Critical Access Hospitals (CAHs), and to certain Rural Referral Centers and Sole Community Hospitals with a DSH percentage greater than 8%. The current program helps safety-net hospitals serve some of their most vulnerable patients. **We urge Congress to further strengthen this important program by expanding it to include inpatient drugs and to allow Medicare dependent hospitals to also participate.**

Wage Index Methodology Reform

The Patient Protection and Affordable Care Act requires the HHS Secretary to report to Congress by 2012 on a comprehensive reform of the current wage index methodology. **As this reform methodology is developed, IHA asks that the principal stakeholders in the health care field be given opportunities to contribute to the development of a new methodology.**

Physician Payment

Legislated reductions in Medicare payments to physicians and non-physician practitioners have been delayed for the past several years; each year a delay in the implementation of a percentage reduction occurs, the eventual impact of the cut compounds. This year, unless Congress acts, a 21% cut in the Medicare Physician Fee Schedule will take effect. A cut in payment of this magnitude could threaten the availability of physicians to provide services to Medicare beneficiaries. Therefore, **IHA urges Congress to enact a permanent fix to the current Medicare payment system that would result in predictable and fair payment for professional services. At the same time, we request that no redistribution of hospital Medicare payments be used to subsidize this fix.**

PRESERVING THE PARTNERSHIP – HOSPITALS AND GOVERNMENT

Physician Supervision

Requiring physicians or non-physician practitioners to be “immediately available” when hospital staff are performing diagnostic or therapeutic procedures for Medicare outpatients puts an undue strain on rural hospitals, as they must recruit from an increasingly shrinking pool of health care professionals. Therefore, **we ask that the current CMS requirement for direct supervision be revised so that a physician or non-physician practitioner is required to be present at the hospital within the time interval consistent with the Medicare Conditions of Participation for Critical Access Hospitals (i.e., 30 minutes).**

Geographic Variation

The Patient Protection and Affordable Care Act calls for several studies and steps to examine the issue of geographic variation in an effort to evaluate the causes of variation in spending and utilization and to ensure fairness in addressing the issue.

The HHS Secretary will commission two Institute of Medicine studies. One will evaluate hospital and physician geographic adjustment factors, looking at their validity as well as the methodology and data used to create them. Allowable changes will be implemented by December 2012. The second study will examine geographic variation in the volume and intensity of health care services and recommend ways to incorporate quality and value metrics into the Medicare reimbursement system. The Secretary will also convene a national summit on geographic variation, cost, access and value in health care later this year.

In considering strategies addressing geographic variation, **IHA urges that funds not be redistributed from one provider to another. Further, we urge the formation of a provider advisory group to counsel the Secretary on the broad impact of these issues.**

Accountable Care Organizations and Other Pilot Programs

Illinois hospitals appreciate the opportunities presented by health reform to participate in pilot and demonstration programs aimed at redesigning how health care is delivered. For example, Accountable Care Organizations present an opportunity to improve integration of care and promote joint accountability for care delivery. **IHA encourages our Illinois congressional delegation to actively pursue opportunities for Illinois hospitals to participate in these demonstration and pilot programs.** It is also important for Illinois lawmakers to advocate involvement of specific members of the Illinois hospital community to serve on work groups and advisory bodies established to carry out the implementation of health care reform.

WORKFORCE CHALLENGES

Funded GME Positions

IHA appreciates the continuation of existing funding for graduate medical education (GME) and efforts to maximize the number of allotted positions available under the 1997 Balanced Budget Act by addressing the re-distribution of unused and closed hospital slots. However, with the emphasis on preventative and community-based care under the reform law, it is clear that new positions must be added and financially supported in order to train the primary care physicians that will be needed. Due to projected shortages, medical schools are working to increase enrollment by 30%, but these medical students will need teaching hospitals to complete their residency training. Illinois hospitals often fund additional openings with their own dollars because government-funded residency positions have not increased. At a time when demand for physicians is projected to outpace supply by 2020, **we urge that funded residency training positions be increased.**

Representation on the National Health Care Workforce Commission

Expanded coverage, an aging health care workforce, and the increasing demand for health services by baby boomers will lead to a

need for more health care professionals of all types. IHA supports strategies and resources that facilitate coordinated workforce planning involving federal, state and local interests to promote a closer connection between workforce education and training and the delivery of health care services. **We urge the appointment of an Illinois hospital leader to the National Health Care Workforce Commission created under the new federal law,** providing an opportunity for Illinois hospitals to participate in setting the nation's workforce agenda.

"Employee Free Choice Act" (H.R. 1409/S.560)

At a time when health reform and the economy are demanding innovative strategies and solutions, H.R. 1409/S. 560 would impose numerous operational barriers for hospitals, significantly hampering their ability to deliver high quality and cost-effective health care. The proposal's removal of a secret ballot compromises an employee's right to the democratic process of fair elections free of outside influences. Any labor negotiations under the proposed law may prohibit or delay critical processes intended to improve patient outcomes. **We urge Congress to reject proposals that deny workers the right to a secret ballot.**

RURAL ISSUES

In addition to the challenges that all hospitals face, the small and rural hospitals of Illinois struggle with special challenges because of their size, volume, demographics, geographical dispersion, and physician shortages.

Independent Payment Advisory Board (IPAB)

The recently passed health care reform bill establishes an Independent Payment Advisory Board charged with submitting proposals to Congress and the President beginning in 2015 to reduce Medicare spending by targeted amounts. Congress can modify or pass an alternative but would be required to maintain the targeted level of Medicare savings for the year. Hospitals, with the exception of Critical

Access Hospitals, are excluded from IPAB targeted reductions for 10 years. **As a vital part of our rural health care safety net, we urge Congress to exempt Critical Access Hospitals from IPAB.**

Medicare Extenders

The reform legislation extends for one year certain Medicare payment provisions that help rural hospitals. These include the Transitional Outpatient Hold Harmless payments and reasonable cost reimbursement for clinical lab services provided in qualified rural areas. **IHA supports the application of both the outpatient hold harmless and the cost reimbursement of clinical lab services on a permanent basis, beginning in 2011.**

RURAL ISSUES

CRNA Cost Reimbursement for CAHs

Certified Registered Nurse Anesthetists (CRNAs) fill a critical role in the delivery of services to Medicare patients in rural communities, especially those served by Critical Access Hospitals. These hospitals receive reimbursement for costs of services provided to Medicare beneficiaries; however, this reimbursement principle has not been applied to CRNA services. For the past several years, hospitals have been reimbursed for their costs of employing CRNAs based on

the Medicare physician fee schedule, amounts significantly lower than actual costs. In addition, the costs incurred for CRNAs to provide “on-call” services are not reimbursable at all. These two reimbursement shortfalls place a huge financial burden on rural hospitals already facing financial stresses. **IHA urges Congress to legislate that reasonable cost reimbursement for these CRNA situations apply to CAHs** (as included in S. 1585, sponsor: Sen. Richard Durbin, and H.R. 3151, sponsor: Rep. Phil Hare).

LEGAL AND REGULATORY BARRIERS

Health Information Technology

Congress passed legislation in 2009 containing measures to jump-start the adoption of health information technology, namely Medicare and Medicaid payment incentives for hospitals who are “meaningful users” of certified electronic health records (EHRs) by specified dates. Congress left CMS to define what constitutes meaningful use by regulation, and CMS published a proposed rule on January 13, 2010. Hospitals failing to become meaningful users by 2015 will be subject to significant payment penalties. IHA, along with 249 members of the U.S. House of Representatives (including 16 members of the Illinois delegation) and 27 U.S. Senators, have expressed major concerns about two key areas of the proposed rule:

- **Meaningful Use Definition**
CMS’ proposed rule’s definition and requirements for hospitals to become qualified as “meaningful users” pose several concerns. It runs counter to Congressional intent to reward hospitals that already have worked towards implementing EHR systems and to incentivize further development. In addition, the rule’s all-or-nothing approach, requiring hospitals to adopt all 23 individual EHR objectives is something that very few hospitals can achieve within the published timelines. **We urge a staged implementation, allowing additional time for hospitals to meet the criteria required to access much needed HIT funding and the rewarding of hospitals for EHR efforts already underway.**

- **Multi-Campus Hospital Limitation**

The proposed rule also limits the number of hospitals eligible for participation in the program by proposing to use Medicare provider numbers to distinguish hospitals for EHR incentive payment purposes. A single provider number can include multiple campuses of a hospital system – and therefore that system would receive one incentive payment for the entire system, while other hospital systems may have multiple provider numbers and thus be eligible for separate payments. **Identifying hospitals as distinct facilities of service** could ensure that individual hospitals would be eligible to separately qualify for incentives and not be wrongly limited by their belonging to a system. In addition, **all categories of hospitals should be allowed to participate, such as rehabilitation, psychiatric and long term acute care hospitals.**

IHA thanks our members of Congress who have weighed in with CMS on these key issues and urges that Congressional intent is followed throughout the rulemaking process.

LEGAL AND REGULATORY BARRIERS

Hospital-Physician Collaboration

The health care reform law seeks to re-engineer the health care delivery system so that it delivers better outcomes more efficiently. Achieving the objectives of health care reform will depend in large measure on the ability of hospitals and physicians to work closely on many delivery fronts. Yet, existing federal law places massive, and sometimes insurmountable, barriers to such hospital-physician collaboration. The following federal laws stand in the way of achieving the nation's health care reform goals:

- **Anti-Kickback Statute**
Hospitals are extremely limited in their ability to offer a physician anything of value for fear that will be deemed an illegal kickback for the physician's referral of patients to a hospital, which could be subject to criminal and civil penalties.
- **Antitrust**
Hospitals and physicians may not be able to collaborate on how best to arrange health care services in a particular community for fear that they will be found guilty of restraining trade under the antitrust laws.
- **Civil Money Penalties**
Perhaps the most anti-reform law on the books, hospitals may not be able to reward physicians for providing care more efficiently for fear of violating the prohibition against incentivizing a reduction in health care services.

- **Federal Tax Exemption**

The federal 501(c) (3) tax exemption under the Internal Revenue Code prohibits exempt hospitals from having any "excessive" compensation arrangements with physicians. The vagueness of what is "excessive" places additional pressure and legal compliance costs on hospitals trying to establish productive relationships with physicians.

- **Stark Laws**

Under the Stark laws governing physician self-referral, a hospital and physician may not jointly own certain health care facilities that provide certain services if that physician plans to refer patients to such facilities. Thus, the law allows a physician to create a facility that he/she values enough to own, but bars him/her from using that facility for his/her own patients.

Illinois hospitals believe that the future health care delivery system should develop naturally without the added burdens of compliance with laws designed for a different time and delivery system. **These five laws should be modified in cases where the social benefits of doing so outweigh the enforcement concerns underlying these laws.**

MEDICAL LIABILITY REFORM

The Medical Liability Crisis in Illinois

In 2005, after three years of debate, the Illinois General Assembly passed comprehensive medical liability reform with bi-partisan support, including caps on non-economic damages. But in February 2010, the Illinois Supreme Court struck down the 2005 medical liability reform law, holding that the damage limitation violates the constitutional principle of separation of powers by interfering with the authority of judges and juries to determine the amount of damages.

During the height of the medical liability crisis, people in large parts of the state found it impossible to get the medical care they needed. Physicians were leaving the state, retiring early, and limiting the services they would provide. There were no neurosurgeons south of Springfield. Pregnant women had difficulty finding obstetricians. Hospitals – especially in rural areas – could not recruit needed physicians. Illinois hospitals are deeply concerned that the 2010 decision will renew the medical access crisis for Illinoisans as liability costs for physicians and hospitals are driven to unsustainable levels.

A Federal Medical Liability Solution

It is unlikely that the medical liability system will be reformed under Illinois law. For the sake of Illinois patients seeking adequate access to care, we ask Congress and the President to enact fair and meaningful limitations on non-economic damages awarded in medical liability cases. Caps on non-economic damages are a proven way to reduce medical liability costs so that patient care resources can be spent where they belong. These caps allow a substantial amount for pain and suffering and do not limit compensation for future medical care or lost wages – they only limit the uncontrolled and unquantifiable awards that put hospitals in jeopardy and hinder their abilities to provide quality care to patients. **Accordingly, we urge Congress to enact meaningful and fair limitations on medical liability costs for health care providers.**

The recently enacted federal reform law provides grants for pilots and other studies aimed at identifying additional medical liability reform possibilities. Given the legal climate in Illinois which promotes defensive medicine, **we ask that Illinois be given high priority consideration for participation in pilots and demonstrations aimed at meaningful medical liability reform.**

Illinois hospitals are grateful for the opportunity to raise these issues with our members of Congress. We look forward to working as partners with our Illinois Delegation to ensure that America's health care system remains strong for all who depend on it for care, and we stand ready to serve as a resource



Illinois Hospital Association

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