



American Hospital
Association

Advocacy Action

ALERT!

Wednesday, August 5, 2009

NEED ACTION FROM..... *All hospital leaders*
ACTION *Deliver reform message to senators and representatives*
WHEN *Throughout August recess*
HOW *Visits, town hall meetings, others*

CONGRESS IS HOME FOR AUGUST ... WORK WITH YOUR LEGISLATORS TO GET REFORM RIGHT!

Congress is heading home for its August summer recess. The House recessed last Friday, and the Senate will recess this Friday. Officially known as the "Summer District Work Period," this is the perfect opportunity for you to contact your legislators while they are home hearing what your community has to say about health reform. It is important that your voice, as a community and health care leader, be heard as well!

This special recess *Alert* contains advocacy messages, tips on summer activities you can undertake, help with setting up a meeting and other tools to help your summer advocacy efforts. And remember to check in regularly at *Health Reform Update* at www.aha.org for updates as they happen.

(Call 1-877-242-2240 or e-mail AHAadvocacy@aha.org to let us know how your contacts go ... thanks!)

Hospitals' August Message to Legislators

([Click here](#) for a “snapshot” comparison of the health care reform bills being considered in the House and Senate.)

To all your legislators:

Hospitals are deeply committed to comprehensive and meaningful reform that expands health care coverage to all Americans.

Recognizing the need to reduce the rate of increase in health care spending, the hospital field and the AHA provided leadership in identifying \$155 billion in Medicare and Medicaid savings as the field's portion of “**shared responsibility**” toward reform. That amount is tied to the expansion of coverage to at least 95% of Americans. Any savings beyond this agreed-to amount would harm hospitals' ability to provide the care their communities need.

To your senators:

Support the reform package being developed by Senate Finance Committee Chairman Max Baucus (D-MT). It reforms the system in a meaningful and thoughtful way, and caps our “shared responsibility” at \$155 billion over 10 years.

To your representative:

We applaud that House legislation expands coverage to more Americans, but we have serious concerns about three provisions that would harm the ability of hospitals to take care of people:

- A **public insurance option partially based on Medicare rates** ([Click here](#) for a one-pager with details on the public plan option).
- An overly aggressive policy on **hospital readmissions** ([Click here](#) for a one-pager on this issue).
- **Accountable care organization** provisions that omit hospital leadership ([Click here](#) for a one-pager on these organizations).

(Call 1-877-242-2240 or e-mail AHAadvocacy@aha.org to let us know how your contacts go ... thanks!)

How to Deliver the Message

([Click here](#) for an AHA Legislative Manual on communicating with Congress; it may help as you set up meetings and other communications throughout the summer.)

- **Invite** your members of Congress to your hospital. Take them on a tour, give them a chance to talk to staff, patients and family members. Provide an opportunity for staff to ask and answer questions of your guests. Let them see the good you are doing for your community.
- **Ask** legislators to attend a meeting of your Board.
- **Attend** a town hall meeting organized by your legislator. Lawmakers have been advised by House and Senate leaders to organize these local events to get the pulse of the public on reform ... make your voice heard as well.
- **Write** a Letter to the Editor of the local newspaper with our advocacy message. Draw from your experience serving the needs of your community ([Click here](#) for a sample Letter to the Editor you can tailor to your needs).
- **Visit** your lawmaker in his/her district office. Take the opportunity to connect with the local staff ... they are the “eyes and ears” of lawmakers back home.
- **Check** whether your local talk radio or TV station might want to feature your perspective on reform, as a community, business and hospital leader on the front lines of care.
- **Send** an e-mail or place a call to communicate your message if you can’t meet your lawmakers in person over the next few weeks. Be sure to be brief and to the point, and encourage a response.

If you wish to subscribe or unsubscribe from this publication, please click [here](#) and include subscribe or unsubscribe in the subject line and your contact information in the body of the e-mail.

(Call 1-877-242-2240 or e-mail AHAadvocacy@aha.org to let us know how your contacts go ... thanks!)

**AMERICAN HOSPITAL ASSOCIATION
HEALTH CARE REFORM LEGISLATION
SNAPSHOT COMPARISON OF KEY ISSUES
AS OF AUGUST 4, 2009**

| KEY POLICY | HOUSE | | | SENATE | |
|--|--|---|---------------------------------|--|--|
| | Energy & Commerce | Ways & Means | Education & Labor | HELP | Finance Committee |
| COVERAGE | | | | | |
| Coverage | Expands coverage to 94% of those residing in the U.S., or 97% of all Americans, through insurance reforms, an individual mandate, low-income subsidies, an employer “play or pay,” Medicaid expansion, and a new insurance “exchange.” | | | | |
| Public Plan | Creates a government-run public plan that would negotiate payment rates with providers. Payments would be set between aggregate Medicare rates and the average aggregate payment rates paid by private plans in the exchange. Allows states an option to set up their own “exchanges” based on co-op structures. Hospitals participating in Medicare may “opt-out” of the government-run plan. | Creates a government-run public plan that would pay hospitals Medicare rates for 3 years. In year 4, Secretary establishes a provider rate-setting system. Hospitals participating in Medicare may “opt-out” of the government-run plan. Physicians’ payment is Medicare + 5% if they participate in both Medicare and the government-run plan. | Same as Ways & Means provision. | Creates a government-run public plan where the Secretary of HHS would negotiate provider payment rates. These rates could not be higher than the average payment rate paid by private plans in the exchange. | Envisions a network of non-profit, non-government entities offering health plans that would be required to negotiate rates with providers and would compete with commercial insurers. |
| Disproportionate Share Hospital (DSH) Payments | Beginning in FY 2017, would gradually reduce Medicare DSH payments to hospitals by \$10.2 billion if there is a significant decrease in the number of uninsured. Medicare DSH payments could be partially restored for some hospitals based on amount of uncompensated care the hospital provides. Medicaid DSH payments to states would be reduced by \$6.4 billion, beginning in FY 2017. <i>CBO Score: Saves \$16.6 billion/10 years</i> | | | No provision | Beginning in FY 2015, calls for gradually reducing Medicare DSH by \$25 billion and Medicaid DSH by \$25 billion, if there is a significant decrease in the number of uninsured. <i>Impact: Saves \$50 billion/10 yrs</i> |

| KEY POLICY | HOUSE | | SENATE | |
|---------------------------------------|---|--------------|-------------------|---|
| | Energy & Commerce | Ways & Means | Education & Labor | HELP Finance Committee |
| DELIVERY SYSTEM REFORM | | | | |
| Readmissions | Reduces all Medicare hospital inpatient payments to prospective payment system (PPS) hospitals and critical access hospitals (CAH) with actual readmission rates higher than their expected 30-day readmission rates for heart attack, heart failure and pneumonia. The Secretary could expand the list of conditions in FY 2013. The largest reduction for a hospital would be 1% beginning in FY 2012, growing to 5% for FY 2015 and beyond. Reduces payments to post-acute providers as well. <i>CBO Score: Saves \$19 billion/10 years</i> | | No provision | Calls for a targeted plan that would focus on reducing certain “avoidable” readmissions related to the initial admission, similar to AHA principles. <i>Impact: Saves \$2 billion/10 yrs</i> |
| Bundling Payments | Requires HHS Secretary to develop a <i>plan</i> to reform Medicare post-acute care (PAC) services, including skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, hospital-based outpatient rehabilitation facility, and home health agency services. The <i>plan</i> should include detailed specifications for bundling payment for PAC services and also could include other approaches. In developing the <i>plan</i> , the Secretary would consider among many issues to whom payment would be made, whether inpatient hospital services should be included in the bundle (and if so, which services) and whether critical access hospitals should be included in the bundle. <i>No budgetary impact</i> | | No provision | Establishes <i>pilot projects</i> to explore bundled payment, followed by evaluation. Would require Congressional approval before implementation. <i>No budgetary impact</i> |
| Value-Based Purchasing (VBP) | The House could include a VBP program in its bill. If such a program is included, it is expected to be the <i>Quality First Act of 2009</i> (H.R. 1776). <i>Impact: Budget neutral</i> | | No provision | Establishes a VPB program that is largely consistent with AHA principles. <i>Impact: Budget neutral</i> |
| Physician Self-Referral | Restrictions are placed on physician self-referral to hospitals in which they have an ownership interest, and limits are placed on expansion for those facilities that are grandfathered. <i>CBO Score: Saves \$1 billion/10 years</i> | | No provision | Restrictions are placed on physician self-referral to hospitals in which they have an ownership interest, and limits are placed on expansion for those facilities that are grandfathered. <i>CBO Score: Saves \$1 billion/10 yrs</i> |
| Accountable Care Organizations (ACOs) | Establishes pilot projects in which physician groups or “other physician organizational models” may form ACOs which could receive incentive payments for coordinating and improving patient care and reducing costs subject to a target performance amount. To form ACOs, physician groups must meet certain requirements, and they may, but are not required to, include a hospital or other providers to share in incentive payments. <i>CBO Score: Spends \$2 billion/10 years</i> | | No provision | Calls for voluntary pilots where groups of qualifying providers (including hospitals) could form ACOs and share in Medicare cost savings. <i>Unknown impact.</i> |

| KEY POLICY | HOUSE | | SENATE | |
|---------------------------------------|---|--------------|-------------------|---|
| | Energy & Commerce | Ways & Means | Education & Labor | HELP Finance Committee |
| MEDICARE AND MEDICAID PAYMENTS | | | | |
| Market Basket Update | <p>Reduces Medicare updates permanently by a measure of productivity growth for inpatient prospective payment system (IPPS), outpatient prospective payment system (OPPS), inpatient rehabilitation hospitals (IRF), long-term care hospitals (LTCH) and psychiatric hospitals.</p> <p><i>CBO Score: Saves \$119 billion/10 years</i></p> | | No provision | <p>Calls for reduced Medicare updates by a measure of productivity growth of, on average, approximately market basket minus 1.0 percent for IPPS, OPPS, IRF, LTCHs, and psychiatric hospitals for FY2010-2019. Cuts would be smaller in the earlier years, ramping up to larger cuts in later years, with a trigger attached to coverage expansions.</p> <p><i>Impact: Saves \$103 billion/10 yrs</i></p> |
| Physician SGR | <p>Permanently reforms the formula that updates Medicare physician payment rates.</p> <p><i>CBO Score: Spends \$228.5 billion/10 years</i></p> | | No provision | <p>Unknown. Finance Committee options paper calls for a temporary fix of the SGR formula from CY 2010-2012.</p> |
| Graduate Medical Education | <p>No cut to indirect medical education (IME) payments; Redistributes unused residency slots</p> <p><i>CBO Score: Spends (with other proposals) \$1.5 billion/10 years</i></p> | | No provision | <p>Calls for no cut to IME payments; redistributes unused residency slots</p> <p><i>Impact: Unknown</i></p> |
| Geographic Variation | <p>Calls for an IOM study on geographic variation to determine the accuracy of the geographic adjustment factors under the hospital and physician payment systems, specifically the IPPS area wage index and the physician fee schedule geographic practice cost indices (GPCIs). Provides \$8 billion over 2 years (FY 2012-2013) to make payment rate adjustments; adjustments are budget neutral thereafter.</p> <p><i>CBO Score: Spends \$8 billion/10 years</i></p> <p>Calls for an IOM study on geographic variation and growth in intensity and services in per capita health spending and on whether payment systems should be modified to incentivize “high value” care, including consideration of the adoption of a “value index.” Mandates a fast-track process for Secretarial and Congressional review and adoption of possible payment system changes.</p> | | No provision | Unknown |

* CBO scores are included if known. The Senate Finance Committee financial impacts are estimates.

The Public Plan Option included in H.R. 3200: *The America's Affordable Health Choices Act of 2009*

House reform legislation creates a government-run, public insurance plan option under the premise of offering consumers greater choice and affordability in health plans. The AHA has serious concerns about the public plan options, particularly in how hospital payment rates are determined in the House Ways & Means, Education & Labor, and Energy & Commerce committee versions of HR 3200:

- In general, HR 3200 includes an expansive public plan that is available on day one of the national health insurance exchange and can be offered only through the exchange. In the first two years the exchange is operational, the public plan is limited to the uninsured, self-employed, and small businesses. Beginning in year three of the exchange, the public plan could be expanded to large employers as defined by the exchange commissioner.
- The Ways & Means and Education & Labor public plan establishes a clear link to Medicare rates for hospital payment, while the Energy & Commerce legislation partially links payments to Medicare rates.
 - The public plan in both the House Ways & Means and Energy & Commerce versions pays hospitals at Medicare payment rates for the first three years of the exchange.
 - In the Ways & Means and Education & Labor versions, the Secretary of Health and Human Services (HHS) would establish a rate-setting process for hospitals, but such rates could not be more than the Medicare rates used in the first three years of the exchange.
 - The Energy & Commerce version would require that, beginning in year four, the HHS Secretary establish a process where rates are negotiated with hospitals, but those negotiated rates are not unfettered and are constrained by a floor and ceiling. The negotiated rates could be no lower, in the aggregate, than Medicare rates and no higher, in the aggregate, than the average rates paid by the health plans operating within the exchange.
- Tying the public plan payment rate to Medicare could result in significant losses in revenues to hospitals, as people and employers choose to enroll in the public plan because of the lower premiums made possible by the underpayment of providers. A public plan paying hospitals at Medicare rates could result in billions of annual lost revenues to hospitals.

AHA View

- The public plan should be limited to the uninsured, self-employed and small businesses – those most in need of help to purchase health care coverage.
- A new public plan should not exacerbate the underpayment of providers by paying rates at Medicare levels. The Medicare Payment Advisory Commission projects that hospitals will have a *negative* 6.9 percent Medicare margin in 2009 – down from a *positive* 6.2 percent Medicare margin in 1999 – the lowest level in more than a decade. According to AHA annual survey data, a staggering 58 percent, or 2,840 hospitals, lost money serving Medicare patients in 2007.
- Any public-sponsored insurance option should require that provider payments be based on negotiated rates with no link to Medicare payment rates.



Hospital Readmissions Policy in H.R. 3200: *The America's Affordable Health Choices Act of 2009*

The policy in the House reform bill would link hospital performance on readmissions to Medicare payments, and represents a potential cut of \$19 billion dollars to America's hospitals over 10 years. Beginning in Fiscal Year (FY) 2012, it would reduce payments to hospitals, including critical access hospitals, with higher-than-expected 30-day readmission rates for heart attack, heart failure and pneumonia. *This payment cut would apply to ALL Medicare discharges – not just the cases involved in a readmission.*

- In FY 2012, the largest reduction for a hospital would be 1 percent, with the reduction growing to 5 percent in FY 2015 and beyond. In 2013, the Secretary of Health and Human Services would have authority to expand the policy to an unlimited number of other conditions.
- Post-acute care providers, including skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals and home health agencies, would experience reduced payments for readmissions starting in FY 2012.

AHA View

- The proposal is overly aggressive. Under the proposal, hospitals' actual readmission rates would be compared to their expected readmission rates for the three conditions, and any hospital with even *one* readmission more than they were expected to have would be financially penalized. These penalties would be significant, applied to *every single* Medicare discharge, not just discharges for heart attack, heart failure and pneumonia.
- Preventing unnecessary hospital readmissions is a complex, system-wide goal that involves hospitals, physicians and other providers who manage patients' care, as well as patients and their families. Hospitals have an important role in preventing unplanned admissions that are related to the initial admission, but other parts of the health care system also must do their part. The proposed policy does not take into account the system-wide approach that is necessary. While skilled nursing facilities, for example, also would receive payment penalties as a result of the House provision, the provision provides few tools for hospitals, post-acute providers and physicians to work together toward improving patient care.
- The examination of hospital readmissions data is relatively new and more work is needed to understand it and determine how to effectively reduce inappropriate readmissions. The proposed policy would financially punish hospitals without attempting to fix other shortcomings of the health care system. In addition, the provision would give the Secretary the ability to rapidly expand the program.
- In short, the hospital readmissions policy in the *America's Affordable Health Choices Act* is the wrong approach to achieving our shared goal of improving patient care and reducing unnecessary hospital readmissions.
- The Senate Finance Committee is proposing a more modest, targeted readmissions policy. We need to convince House members that the current provision in the House bill is flawed, and ask them to embrace the more measured approach being developed by the Senate Finance Committee addressing unplanned admissions related to the initial admission.



American Hospital
Association

Accountable Care Organizations (ACOs) in H.R. 3200: *The America's Affordable Health Choices Act of 2009*

House legislation permits Medicare to pilot programs in which accountable care organizations (ACOs) are paid to manage the health care of defined populations beginning in January 2012. ACOs are defined by the House as groups of physicians or physician organizational models that:

- Have a legal structure that would enable the group to receive payments and distribute incentives;
- Have a sufficient number of primary care providers to serve the population for which they are assuming accountability;
- Collect and report on quality data and other information specified by the Secretary of Health and Human Services (HHS) to enable the evaluation of the success of the pilot;
- Notify the applicable beneficiaries as determined appropriate by the Secretary;
- Contribute to a “best practices” Web site specified by the Secretary for sharing of effective strategies for improving care and efficiency;
- Use patient-centered care processes; and,
- Meet other criteria set by the Secretary.

ACOs may be paid either on a performance target model or on a partial capitation model. In the performance target model, an ACO that shows acceptable performance on quality metrics and whose per capita expenditures are less than the targeted amount, is eligible to receive an incentive payment equal to part of the savings that results from having expenditures less than the targeted amount. The targeted amount is calculated based on the amounts previously spent under Medicare Parts A and B on similar patients in previous years, adjusted for inflation and other trends in health care costs.

The partial capitation model puts the ACOs at risk for some, but not all, of the costs of care for the beneficiaries included in the ACO's defined population, such as all Part B services or only services related to physician services. The House legislation also enables the public plan to experiment with payments to ACOs, and the House Energy & Commerce Committee's bill extended this concept to enable Medicaid programs to pilot programs as well.

AHA View

- We believe the emerging Senate Finance Committee legislation will also include an ACO pilot that allows groups of qualifying providers – such as individual physician practices, physician group practices, hospital-physician joint ventures and hospitals employing physicians – to voluntarily form ACOs and share in the cost savings they achieve for Medicare.
- This opportunity should not be limited to physician groups and physician organizational models, as it is in the House legislation.
- ACOs offer an opportunity to improve integration of inpatient and outpatient care and promote joint accountability for care delivery across providers and across time. Hospitals and health care systems are well-positioned to provide the organizational structure that underlies the functioning of a successful ACO.

SAMPLE Letter to the Editor

Attached below is a sample Letter to the Editor that can serve as a framework for a personalized submission. Letters are typically submitted in response to an article or opinion piece that has appeared in the paper, so as you keep current on local coverage of the health care reform debate look for an article you feel warrants a response or one where you might offer a unique perspective. Please check with your specific news outlet as to their preferred length ... a general rule of thumb is that your letter should be less than 250 words.

Dear Editor,

Hospitals play a vital role in communities across this country, providing ALL Americans with access to needed health care services... and now hospitals are also playing a key role in the current health care reform efforts. America's hospitals support meaningful reform, and to illustrate this commitment have come forward and made the largest good faith effort to date – agreeing to reductions of \$155 billion to help advance coverage for virtually all Americans.

At (name of local hospital), we work every day to provide quality care for all patients, but we also see first-hand the impact of our nation's broken health care system. The end result—patients with no access to primary or preventative care are coming to the hospital without insurance; they are sicker and often with chronic conditions that makes providing care more complicated and more costly.

While there is still much work to be done in Washington, all stakeholders – insurers, suppliers, unions, employers, providers and individuals - must step forward and do their part if we going to achieve meaningful reform. Additionally, it is critical that any health reform bill be based on expanding coverage to at least 95% of the population and must ensure that our hospitals remain strong and able to provide care to patients and communities.

(PLEASE INSERT LANGUAGE TO PERSONALIZE THIS LETTER – YOUR HOPE FOR HEALTH REFORM, CONCERNS ABOUT WHAT HEALTH REFORM COULD MEAN FOR YOUR HOSPITAL AND COMMUNITY, OR A BROAD HOSPITAL CONCERN, SUCH AS THE EXPANSIVE PUBLIC PLAN BASED ON MEDICARE RATES, AN AGGRESSIVE READMISSIONS POLICY, AND ACCOUNTABLE CARE ORGANIZATIONS.)