Synopsis of Major Hospital Payments Targeted To Date

Since 2011 multiple payment cuts to hospitals have been proposed. The following list is a sampling of the major Medicare and Medicaid cuts proposed to date; however, this is not an exhaustive list. The Wisconsin Hospital Association anticipates these issues will continue to percolate in the coming year as Congress looks for funding sources for various fiscal and budget needs. In several instances, cuts have already been enacted. Those are denoted in red.

- **Medicaid Provider Assessments** – Multiple proposals have targeted Medicaid provider assessments. Nearly every state has some form of a provider assessment, including Wisconsin. Use of provider assessments has allowed state governments to maintain patient access to health services by avoiding additional provider payment cuts. Various federal proposals have suggested a phase down of Medicaid provider taxes or even their eventual elimination. Wisconsin has successfully implemented a hospital assessment backed by the WHA and hospitals. It has helped ensure health care is available to low-income Wisconsin citizens across the state. Regardless of the federal proposal, the WHA supports use of provider assessments and is concerned by the impact of such proposals on Wisconsin’s Medicaid population, which now accounts for 20% of the state’s residents.

- **Reductions To Hospital Medicare Bad Debt Payments** – The Medicare program requires its beneficiaries to pay a portion of the cost of their care. Many low-income beneficiaries cannot pay these amounts to the hospital, resulting in unpaid debt (i.e.: “bad debt”). Historically, the Medicare program has reimbursed hospitals for a portion of the debt incurred by Medicare beneficiaries, particularly those with low incomes. Various federal proposals have been offered to reduce or eliminate bad debt payments altogether. In early 2012, a provision was enacted in the Middle Class Tax Relief and Job Creation Act to reduce bad debt payments for hospitals. Bad debt payments are reduced for inpatient prospective payment system (PPS) hospitals from 70 to 65 percent and from 100 to 65 percent for Critical Access Hospitals. This cut will cost Wisconsin hospitals an estimated $55 million. The impact on Wisconsin hospitals could be even larger under a State policy change for dual eligibles that is simultaneously being implemented.

- **Critical Access Hospitals (CAHs)** – Small, rural hospitals face a unique set of challenges because of their remote geographic location, small size, scarce workforce, physician
shortages and constrained financial resources with limited access to capital. Congress has previously recognized these vulnerabilities by establishing programs and policies to ensure and protect stable access to health care services for the elderly and others living in rural America. One designation created was the critical access hospital (CAH). Wisconsin has 58 CAHs. Some policymakers are suggesting significant changes to the CAH program, including outright elimination of CAH designation and/or mileage restrictions. One specific proposal has been to eliminate CAH designation for CAHs that are 10 miles from another hospital. This proposal would eliminate CAH designation for eight Wisconsin hospitals. Should that mileage restriction be increased to 15 or 20 miles, far more Wisconsin CAHs would be impacted. The CAH program has worked extremely well in Wisconsin, keeping health care available in rural communities across the state. WHA strongly opposes proposed changes to this designation.

- **Evaluation & Management Services (Hospital Outpatient)** – MedPAC adopted a policy that would cap “total” payment for non-emergency department evaluation and management (E/M) services in hospital outpatient departments (HOPDs) at the rate paid to physicians for providing the services in their offices. The most recent federal proposal offered up for savings would have reduced the hospital payment by at least 71 percent for 10 of the most common outpatient hospital services. Under a proposal such as this, WHA estimates Wisconsin hospitals will lose over $450 million over 10 years. WHA opposes these proposals because E/M services provided by a physician in a physician office setting are fundamentally different than the services provided in the HOPD.

- **Medicare Documentation & Coding Adjustments** - Beginning in fiscal year (FY) 2008, the Centers for Medicare & Medicaid Services (CMS) refined the method it used to categorize patients for purposes of payment under the PPS, with the promised goal of more accurate payments to hospitals. In every year since then, CMS has claimed that any increases in payments to hospitals have been due solely to these changes in coding, and not to any changes in patients’ actual severity of illness. As a result, CMS has cut nearly $10 billion out of hospitals’ payments over the past five years, asserting that these represent overpayments due solely to coding changes. CMS continues to propose additional cuts through rule and some in Congress have proposed even further cuts as a means to find additional “savings.” Under the American Taxpayer Relief Act of 2012 (ATRA), legislation passed to avert the “fiscal cliff”, Congress agreed to cut PPS hospitals under this “coding offset.” This cut nationally was $10.5 billion over four years. WHA estimates the impact on Wisconsin hospitals at over $161 million over four years. WHA continues to fundamentally disagree with the contention that documentation and coding changes due to the move to MS-DRGs are the result of “upcoding” and not reflective of real changes in case mix, patient characteristics and treatment patterns in our hospitals.

**Wisconsin hospitals will lose an estimated $161 million dollars over four years under this coding offset.**
• **Graduate Medical Education Payments** - Some policymakers are advocating for a significant reduction in Medicare graduate medical education payments to teaching hospitals. The two major cuts that have been targeted are: capping Direct Graduate Medical Education Payments (DGME) at 120% of the average nationwide average per resident salary; and cutting Indirect Medical Education Payments (IME) by 40% cut. Nationally, these cuts would total $9.9 billion for direct costs and $44.8 billion for indirect costs over a ten year period. For Wisconsin, WHA estimates the cuts at over $775 million over 10 years. WHA recently released a report that found the state needs an additional 100 physicians per year to address future demand due to baby boomers and health care expansion under the new reform law. Cutting graduate medical education payments works at cross-purposes to other stated goals by Congress and the President. WHA opposes cuts to Wisconsin’s teaching hospitals.

• **Outpatient Therapy Caps** – Medicare limits the annual amount for Medicare beneficiaries for certain outpatient therapy services, including physical therapy, occupational therapy among others. Those caps have previously *not* applied to hospital outpatient departments (HOPDs). In 2005, Congress passed legislation allowing for exceptions to this cap. Some have proposed extending the caps to HOPDs. In February 2012, the Congress passed and President signed into law the Middle Class Tax Relief and Job Creation Act of 2011, which extended the therapy caps (and exceptions process) for 10 months to the hospital outpatient department setting. WHA opposed this extension because of the current payment differential between the HOPD and other settings and because a physician order is required to initiate a plan of care in an HOPD, which also helps to control utilization.

• **Inpatient Rehabilitation Facilities (IRFs)** – Over the years, policy and payment changes have been implemented regarding criteria for IRFs and IRF patients. One change is a threshold that requires admissions to IRFs have one of 13 qualifying medical conditions. That threshold had been 75% but was lowered to 60% several years ago. This is now known as the “60% rule.” However, some are now advocating a return to the 75% threshold. WHA opposes the return to this threshold because Medicare should not require IRFs to provide hospital-level services but pay for them at Skilled Nursing Facility rates. Additionally, there has been a decline in IRF admissions over the years, demonstrating the appropriate use of this treatment setting.