



Arizona Hospital and Healthcare Association

October 6, 2011

The Honorable Jon Kyl  
U.S. Senate  
730 Hart Building  
Washington, D.C. 20510

Dear Senator Kyl:

On behalf of the Arizona Hospital and Healthcare Association (AzHHA) and our 102 hospital members, I write to express appreciation for your efforts as Congress convenes this fall, and the Joint Select Committee on Deficit Reduction deliberates options for reducing the federal deficit. AzHHA recognizes the vital need to ensure the long-term stability of our nation's economy, as well as our healthcare delivery system. As Congress begins its work on the deficit, we urge you to bear in mind the invaluable contribution that Arizona's hospitals make to our state's economy and the crucial role they play in delivering quality care to its residents.

Throughout the recession, and despite federal and state provider payment cuts under Medicare and Medicaid, hospitals have been one of the few industries to maintain job growth. In 2009, Arizona hospitals generated \$13.8 billion in direct output, or 5.2 percent of the state gross domestic product. Arizona hospitals employ approximately 80,000 physicians, nurses, administrative and support staff—or 2.8 percent of the state's workforce. The average hospital worker in Arizona earns \$64,600. Regrettably, several of the deficit reduction proposals that impact Medicare and Medicaid provider payments put these high-quality jobs at risk. Such job losses will further erode Arizona's fragile economy. AzHHA believes there are better alternatives to reduce healthcare costs and improve our fiscal future, which are outlined below.

As AzHHA has previously pointed out, Arizona hospitals have sustained significant payment cuts under the *Affordable Care Act (ACA)*—\$1.8 billion over 10 years. Reductions imposed by federal regulations, such as the Medicare inpatient prospective payment system (PPS) coding offset, will cost Arizona hospitals another \$156 million over the next two fiscal years. At the state level, Arizona Health Care Cost Containment System (AHCCCS) payments to hospitals have been cut 10 percent this year—5 percent on April 1, 2011, and 5 percent scheduled to take effect October 1, 2011. This comes on the heels of a rate freeze and additional payment cuts imposed on Arizona hospitals since the recession began in 2008. In total, Arizona hospitals will have lost over \$1 billion in Medicaid payments from FY 2008 through FY 2012.

At the same time that public payors are slashing hospital payments, demands by federal regulators on hospital workers continue to grow. Hospitals must invest significant financial resources and train staff to meet new federal electronic health record and value-based purchasing requirements, implement new ICD-10 coding standards, and respond to the copious demands of auditors under the Medicare Recovery Audit Contractor (RAC) program.

Additionally, the frail state of Arizona's economy is placing unprecedented demands on hospital emergency departments and inpatient units. The uninsured rate climbed to 19.1 percent in 2010, a number that will grow this year and next with implementation of the freeze on childless adults enrolled in AHCCCS. Hospitals are already reporting that uncompensated care, which stood at \$409 million in 2009, has surged this summer with implementation of the enrollment freeze and phase-out of the state's spend-down program, known as the Medical Expense Deduction program. As you weigh the following deficit reduction options, AZHHA urges you to keep in mind the contribution that hospitals and healthcare workers have already made over the past several years as the country has struggled with the recession, and demands on the safety net have soared.

### Medicare Bad Debt

Under Medicare's statutory reasonable cost principles, costs of care attributable to a Medicare beneficiary cannot be shifted to non-Medicare patients, and vice versa. Thus, when hospitals are unable to collect cost-sharing payments owed by Medicare beneficiaries, they record these payments as bad debt and are reimbursed a portion of the amount directly from the Centers for Medicare & Medicaid Services (CMS).

Currently, Medicare reimburses hospitals for 70 percent of Medicare bad debts. Historically, Medicare reimbursed hospitals for 100 percent of this debt. However, the *Balanced Budget Act of 1997(BBA)* reduced this amount to 75 percent in 1998, 60 percent in 1999, and 55 percent in 2000 and beyond. In the *Benefits Improvement and Protections Act of 2000*, Congress increased bad debt reimbursement to 70 percent when the effects of cutting payments for the most vulnerable and poor Medicare beneficiaries became evident. The Simpson-Bowles Commission and others have advocated eliminating or reducing reimbursement for Medicare beneficiaries' bad debt. Such elimination would cost Arizona hospitals \$276.8 million over 10 years. Under a recent proposal by President Obama to scale back the program to 25 percent reimbursement, Arizona hospitals would lose \$87 million.

It is important to note that Medicare beneficiaries' out-of-pocket expenses can be substantial, particularly for those living on fixed incomes. In 2011, the Part A hospital deductible is \$1,132 per benefit period. The Part B deductible is \$162 per year, and the Part B coinsurance is 20 percent of the Medicare-approved payment amount. In addition, there is a Part B premium of about \$100 per month, which varies depending on the beneficiary's income. Although this premium cannot be turned into bad debt, it still

represents an out-of-pocket expense that could contribute to seniors' inability to pay their other out-of-pocket expenses—deductibles and coinsurance.

Based on 2008 cost reports, Arizona hospitals lose about 8.4 percent on average from Medicare. Reductions to bad-debt reimbursement will exacerbate these losses and contribute to additional cost-shifting to the private sector. Moreover, elimination or reductions to Medicare bad debt reimbursement will disproportionately affect hospitals that treat high numbers of low-income Medicare beneficiaries—urban safety-net hospitals and rural hospitals. Safety-net hospitals will have fewer resources with which to serve low-income Medicare beneficiaries who are unable to afford cost-sharing requirements. Rural hospitals and the patients they serve will be placed under severe stress, as the smaller size of these hospitals leaves them with more limited cash flow and less of an ability to absorb bad-debt losses.

### **AZHHA strongly urges you to oppose reductions in Medicare bad debt reimbursement.**

#### Rural Hospital Payments

Nearly 1.6 million of the state's 6.4 million residents live in rural Arizona. Rural residents tend to be older and poorer than urban residents. The Arizona Center for Rural Health reports 18 percent of rural residents are over age 65 compared to 15 percent of urban residents. According to the U.S. Census Bureau, 16.5 percent of rural residents live below the poverty level compared to 14.9 percent of urban residents. Rural communities have higher rates of chronic illness and disability and poorer overall health status than urban communities. Heart disease, cancer and diabetes rates are higher in rural areas. All of this places additional strain on the rural healthcare delivery system.

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 healthcare services for the elderly and others living in rural America. Specifically, Congress created critical access hospital (CAH), sole community hospital (SCH) and Medicare-dependent hospital designations to sustain these unique types of rural or small hospitals. Some policymakers have suggested eliminating these programs or, in the case of a recent proposal by President Obama, reducing Medicare reimbursement for CAHs from 101 percent of cost to 100 percent. **We strongly oppose these proposals.**

#### A. Critical Access Hospital Payments

In 1997, the *BBA* authorized cost-based inpatient and outpatient payments for hospitals designated as CAHs. Due to their small size and remote location, Congress understood that these hospitals should be carved out of the PPS under which other hospitals are paid.

Originally receiving 100 percent of cost, CAH reimbursement was increased to 101 percent in the *Medicare Modernization Act of 2003*. This additional 1 percent allows CAHs a margin by which they can replace equipment, invest in capital improvements, and provide other important support services to their communities.

It is important to note that the average 2010 operating margin of Arizona's 11 non-Indian Health Services CAHs was negative .68 percent. This margin is estimated to drop to negative 7.2 percent under the FY 2012 AHCCCS budget cuts. Because the combined Medicare and Medicaid utilization rates of nearly every Arizona CAH is well over 50 percent, these hospitals are less able to shift Medicare and Medicaid losses to private payors. If cost-based payments to CAHs are eliminated, Arizona CAHs stand to lose \$88.5 million collectively in *inpatient service reimbursement* over 10 years. This impact is vastly understated as it excludes outpatient services, which make up the majority of CAH services. Under the president's proposal to reduce reimbursement to 100 percent of cost, Arizona CAHs will lose \$6.3 million on *inpatient reimbursement*, a figure that does not take into account losses to outpatient reimbursement. Patient access to care will suffer under both proposals. When combined with recent AHCCCS payment cuts, these proposed reductions to Medicare reimbursement will threaten the financial viability of several Arizona CAHs, some of which may be forced to shutter services.

#### B. Sole Community Hospital Payments

When the outpatient PPS was implemented, Congress made small rural hospitals with 100 or fewer beds eligible for a payment adjustment, referred to as "hold harmless" transitional outpatient payments (TOPs). Hold harmless TOPs were intended to ease these hospitals' transition from the prior reasonable cost-based payment system to the outpatient PPS. That provision originally expired on January 1, 2004; however, because of concerns about the financial stability of these small rural hospitals, Congress has extended the provision and has subsequently expanded it to apply to equally vulnerable SCHs.

Under the "hold harmless" provision, the hospital's Medicare outpatient payment is increased by 85 percent of the amount of the difference between the aggregate reasonable cost-based payment the hospital would have received prior to the enactment of the *BBA* and the aggregate payments the hospital received under the outpatient PPS. In Arizona, 10 hospitals in rural areas of the state are classified as small rural or SCHs, qualifying them for outpatient hold-harmless payments. These payments are scheduled to expire on December 31, 2011.

We are concerned that the small rural hospitals and SCHs that currently receive TOPs will be significantly harmed if these payments are eliminated. According to the American Hospital Association (AHA), the average TOPs that eligible hospitals received in 2010 was \$363,194. While this amount may seem small, the impact of these payments on the hospitals is significant. Hospitals that receive hold-harmless payments in Arizona have

Medicare payments well below their Medicare costs, with payments averaging about 83 percent of cost based on 2008 data. By contrast, the statewide average payment-to-cost percentage is about 91.6 percent.

According to the AHA, 96 percent of all TOPs-eligible hospitals have payment-to-cost percentages that are below the national average. If TOPs hold-harmless payments were eliminated, TOPs-eligible hospitals across the country would see their payment-to-cost percentage fall to 75 percent. This would represent a cut of about 16 percent to Medicare outpatient payments for these hospitals. With such a large gap between payments and costs, it would be difficult for these hospitals to continue to provide access to critical outpatient services, such as chemotherapy.

In addition to the potential cuts to hold-harmless TOPS, should the SCH designation be eliminated altogether as has been suggested by some policymakers, Arizona's SCH hospitals currently opting for the allowed hospital-specific reimbursement rate for inpatient services would lose over \$45 million in the first year, and nearly \$492 million over ten years.

Arizona's rural hospitals serve as an anchor for all of their communities' healthcare services, providing the structural and financial backbone for physician practices, outpatient clinics and, in some cases, post-acute, long-term care and behavioral health services. In addition, these hospitals provide essential related services, such as social work and community outreach. Inadequate reimbursement by public payors threatens access to healthcare in rural Arizona. And because rural hospitals are often the largest or second largest employer in the community, the economy of rural Arizona is at risk when the Medicare and Medicaid programs are cut too deeply.

**We strongly urge you to support the CAH and SCH programs and oppose deep cuts to CAH and SCH payments, including President Obama's proposal to reduce CAH reimbursement to 100 percent of cost.**

#### Graduate Medical Education

Some policymakers are advocating for a significant reduction in Medicare graduate medical education (GME) payments to teaching hospitals. In December 2010, the Simpson-Bowles Commission recommended reducing the indirect medical education (IME) adjustment by 60 percent, from 5.5 percent to 2.2 percent, and limiting hospitals' direct GME payments to 120 percent of the national average salary paid to residents in 2010. These two changes would reduce Medicare GME and IME payments to Arizona hospitals by an estimated \$170.6 million over 10 years. A similar proposal by President Obama would reduce IME payments by 10 percent beginning in FY 2013, and would cost Arizona hospitals nearly \$71 million over 10 years.

Teaching hospitals serve a critical role in Arizona's healthcare delivery system. Not only do they train future physicians, but they also conduct medical research and serve a vital role in caring for our most acutely ill patients. Teaching hospitals are centers of innovation, helping to develop new treatments and cures, and provide highly specialized services such as burn and trauma care. Yet Medicare does not cover the full cost of this care. On average, Medicare margins for teaching hospitals is negative 5.2 percent compared to negative 0.6 percent for all hospitals, according to the Medicare Payment Advisory Commission's March 2011 report.

The Medicare program has long recognized its responsibility for funding its share of the direct and indirect costs of training health professionals. IME payments are explicitly made to compensate for the higher costs associated with teaching hospitals, such as a greater use of emerging technology and greater patient severity. Direct GME payments help fund the teaching costs of residency programs, such as resident salaries and benefits, faculty salaries and benefits, and administrative overhead expenses.

The proposed cuts to Medicare IME and direct GME payments will jeopardize the ability of Arizona's teaching hospitals to train the physicians that Arizona so desperately needs. Hospitals that care for the most acutely ill and that provide specialized trauma and burn care will be forced to reevaluate their residency programs, potentially eliminating valuable services and residency positions. This situation is particularly dire since Arizona has already eliminated state funding for Medicaid GME, and many Arizona teaching hospitals rely solely on Medicare funding for their teaching programs. Reductions to Medicare GME and IME will have ramifications for the entire healthcare delivery system and for Arizona's economy.

**AzHHA urges you to oppose cuts to Medicare direct GME and IME payments.**

#### Post-Acute Care

In recent years, post-acute care hospitals have been subjected to substantial regulatory and statutory payment reductions and restrictions. The ACA included productivity offsets and other reductions to updates and quality reporting requirements for all post-acute sectors, including long-term care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs). Additionally, CMS has significantly tightened the post-acute payment system, including coding and documentation offsets, rebasing and substantial operational changes.

President Obama recently proposed further reductions to post-acute care provider payments and reinstatement of the 75 percent inpatient rehabilitation rule. This rule requires 75 percent of patients treated by an IRF to fall within designated medical conditions. Congress reduced the compliance threshold from 75 percent to 60 percent in 2007 to reflect a more appropriate compliance level. In total, the changes to post acute

care payments proposed by the president would cost Arizona providers \$207 million over 10 years.

**AzHHA urges you to oppose these deep cuts to post-acute care providers.** It is excessive and unjustified to stack additional payment cuts onto the already substantial reductions imposed on post-acute care providers. Such cuts could further exacerbate financial pressures and limit patient access to needed post-acute care services, especially in rural areas. Instead, we urge you to allow the ACA provisions that reform the delivery of post-acute services to be implemented and commensurate savings to take hold. The ACA included several provisions—post-acute care quality reporting and value based purchasing, accountable care organizations and bundling—intended to improve care coordination and heighten accountability for post-acute care and other providers. As a result, proposals are already under way to develop thoughtful and targeted changes to move care delivery away from their current silos to a more integrated care model.

#### Provider Assessments

The Medicaid provider assessments program has historically allowed states to improve Medicaid coverage and bring provider payments closer to cost. During the recession, the program has allowed states to fill Medicaid budget gaps, thereby mitigating provider payment cuts and losses in patient access to care.

The president's deficit reduction proposal cuts this program by \$26.3 billion over 10 years through lowering the assessment rate cap from its current level of 6 percent to 3.5 percent in FY 2017 and beyond. The Simpson-Bowles Commission also recommends restricting, and eventually eliminating, states' ability to finance their Medicaid spending through provider assessments. This proposal to eventually eliminate provider assessments would result in reductions of \$44 billion in the Medicaid program by 2020.

Presently, Arizona finances a portion of AHCCCS through an assessment on the premiums of managed care companies that are contracted with AHCCCS. In response to the more than \$500 million in FY 2012 AHCCCS funding cuts approved by the Legislature, AzHHA and other healthcare stakeholders, community organizations, and business groups, such as the Arizona Chamber of Commerce, have proposed increasing the AHCCCS premium assessment and expanding the assessment to hospitals in an effort to fill Arizona's Medicaid funding gap. While this may not be the permanent solution needed to resolve a structural problem, it is a viable option the state can utilize while policymakers and stakeholders come together to work on permanent solutions. AzHHA and others will continue to urge Arizona lawmakers next session to support a special healthcare assessment—an option that will be eliminated if Congress prohibits new assessments and/or severely restricts existing ones.

**AzHHA urges you to oppose the elimination of or deep reductions to provider assessments as a state Medicaid financing strategy.**

### Blended Medicaid Matching Rate

Currently, CMS matches state contributions for Medicaid at different rates, known as the Federal Medical Assistance Percentages (FMAP). These rates are calculated annually using a formula based on each state's average per capita income. The lower a state's per capita income, the higher its FMAP. By law, no state FMAP can be lower than 50 percent or higher than 83 percent. In addition, states receive an enhanced FMAP for the Children's Health Insurance Program. States will also be eligible for an enhanced FMAP beginning in 2014 for newly eligible individuals enrolled in Medicaid under the ACA.

President Obama and others have proposed replacing the current FMAP and enhanced FMAP rates with a blended rate for each state. Over the course of 10 years, the president's proposal would shift to the states \$14.9 billion in federal Medicaid support. This proposal does nothing to address utilization or other cost drivers in the Medicaid system. It merely places an additional burden on cash-strapped states and providers under the guise of "simplifying" the FMAP formulas. **AzHHA urges you to oppose the adoption of a blended FMAP rate.**

### Sequestered Cuts and Alternatives

If the Joint Select Committee on Deficit Reduction does not recommend and/or Congress does not approve the deficit reduction savings required by the *Budget Control Act*, \$1.2 trillion in cuts to mandatory and discretionary spending would be automatically triggered beginning in FY 2013, including a 2 percent cut to Medicare provider payments. Such formula-driven, sequestered budget reductions are arbitrary in nature, and do nothing to target specific costs that drive healthcare spending. As an alternative approach, AzHHA supports a value-based purchasing system that aligns payments with performance—one that pays for quality outcomes and rewards efficiency. These types of reforms have great promise for reining in healthcare costs and improving patient care.

**AzHHA urges you to oppose an across-the-board cut to Medicare provider payments that could threaten patients' access to care, and instead support the value-based purchasing reforms that hospitals are beginning to implement in compliance with existing federal law.**

To drive down healthcare costs even further and reduce the federal deficit, AzHHA urges you to also consider the following reforms:

- Reducing medical liability costs by passing the *Help Efficient, Accessible, Low-cost, and Timely Healthcare (HEALTH) Act of 2011*;
- Addressing overutilization of Medicare services by implementing income-appropriate beneficiary cost-sharing measures, such a sliding-fee scale for certain Medicare services;

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- Streamlining regulatory requirements, such as those contained in Stark and anti-kickback laws and the RAC program; and
- Examining opportunities to improve revenue collections.

Thank you for the opportunity to share our concerns with you. If you have any questions or comments, please feel free to contact me at your convenience.

Sincerely,

A handwritten signature in cursive script that reads "Laurie Liles".

Laurie Liles

President and Chief Executive Officer