



Health Care Reform Hospital Talking Points

Below are talking points and background information to assist in health care reform conversations with members of Congress.

1. Proposed Cuts to Medicare/Hospital Payments

President Obama announced an additional \$313 billion in cuts to Medicare and Medicaid on top of previously announced \$309 billion in cuts to the federal health programs, contained in his FY2010 budget outline that would be used to pay for health reforms.

Two-thirds of the new proposed spending cuts come from hospital payments. The President proposed \$106 billion in 'savings' by cutting the Medicare and Medicaid DSH programs by 75 percent. In addition, the President proposed \$110 billion in 'savings' by reducing inflationary updates with an annual 'productivity adjustment,' the greatest impact on hospitals.

These 'savings' are in addition to the President's FY2010 budget proposal to cut Medicare and Medicaid spending by \$309 billion. They are also in addition to the \$38 billion in previously announced reform-related cuts, and \$41 billion in cuts in the proposed FY 2010 inpatient PPS rule.

Action Needed:

Hospital advocates should urge Iowa's congressional delegation to resist these proposed cuts, and maintain that cutting hospital payments and programs that will cripple hospitals' ability to care for patients is not health care reform.

Hospitals are committed to finding ways to increase efficiency and reduce costs in the system, but taking across-the-board cuts of this magnitude would be extremely damaging to hospitals. With Iowa hospitals ranking near last in Medicare reimbursements as it stands now, drastic cuts to the program would be devastating. There are other ways to pay for health reform, but requiring hospitals to bear most of the burden is unacceptable.

2. Value-Based Purchasing

IHA supports the concept of moving the Medicare program toward a value-based purchasing (VBP) payment system. In theory, the VBP program would allow hospitals who have higher quality to receive higher Medicare reimbursement. IHA strongly believes that any VBP program must not only recognize high quality but also increased efficiencies in the areas of health care delivery and resource utilization. IHA believes that **efficiency** is the key to long-term

sustainability of the Medicare program. The current proposal as released by the Senate Finance Committee does not include specific efficiency measures for hospitals.

The currently proposed financing mechanism for VBP is also of concern. The Finance Committee's proposal is not budget-neutral. The program would withhold (cut) hospital payments by up to 5 percent and allow the cuts to be recouped based on quality scores (as determined by the Department of Health and Human Services). Further, any funding that is not recovered by hospitals would be used as savings within the Medicare program. With Iowa ranking near last in Medicare reimbursements, this type of financing structure would be harmful to Iowa hospitals because they will likely be disadvantaged as current high performers.

Action Needed:

- Include delivery, resource utilization and efficiency measures to the VBP program to encourage the efficient delivery of care and efficient use of health care resources, with the overall goal of increasing quality and reducing costs.
- Congress should stand behind this proposal and make the investment needed to decrease payment disparities in the Medicare program, reduce losses hospitals incur and pay for the actual cost of health care services. VBP payments should be made on a "bonus" approach versus a payment cut/earn-back.

3. Support for Programs that Support Medical Education

Over the past few years, capital indirect medical education (IME) payments have been threatened with regulatory cuts that have very narrowly been avoided.

Cuts to IME payments are financially damaging to hospitals that rely on funding to provide education to the future health care workforce. With ever-increasing health professional shortage areas in Iowa and across the country, now is not the time to be cutting back or eliminating education payments to teaching hospitals.

Workforce and training initiatives are critical to overall health care reform efforts, and Congress should take action to ensure that medical education funding is a key priority. This includes fully eliminating cuts to the IME program that are currently under Congressional moratorium set to expire in the coming months.

Action Needed:

- Health care reform efforts should recognize the importance of a strong and well-trained health care workforce and take into consideration additional medical education and workforce initiatives that seek to improve, enhance or grow the health care workforce (including or medical education programs and resist future regulatory cuts to Capital IME payments to hospitals).

- Protect GME programs by requiring CMS to fully fund shared intern and resident programs (foundation model) by allowing hospitals the flexibility to count all resident time when the resident trains at a non-hospital site for GME payments, if the hospital incurs all or substantially all of the costs for the training program. This would allow hospitals the flexibility to partner through foundation-model residency programs and limit administrative costs.
- Provide funding to increase the number of residency slots at teaching institutions: A recent University of Iowa study analyzed physician supply concerns and identified the top five areas of physician shortages as psychiatry, neurosurgery, general internal medicine, orthopedic surgery and cardiology. Neurology, obstetrics/gynecology and general surgery also ranked high. By funding additional residency slots, Iowa's hospitals will be more able to recruit physicians and improve access to services for patients.

4. Fixing the Sustainable Growth Rate (SGR) for Physicians in the Medicare Program

The formula that Medicare uses to calculate physician reimbursements is flawed resulting in massive proposed cuts to physician payments on an annual basis that have only been prevented by last-minute Congressional action.

At present, physicians face a potential 21 percent cut in FY 2010 if this formula is not corrected.

Action Needed:

- As part of health care reform efforts, Congress should find a solution to the flawed SGR formula and fix the physician payment issue once-and-for-all.

5. Addressing “Low-Volume” (Tweener) and Rural Referral Hospitals.

Tweener hospitals are rural hospitals within the prospective payment system that, due to low Medicare patient volume, experience disproportionate payment shortfalls.

The tweener “fix” language that provides a “low-volume adjustment” has been inserted and removed from a half-dozen bills over the past few years. The issue did not receive adequate Congressional attention as there are relatively few tweener hospitals nationwide and the specificity of the issue makes it difficult to insert into other legislation.

Rural referral although not low volume are uniquely impacted by disproportionate Medicare and Medicaid payments as well, and would also benefit from a low-volume adjustment.

Action needed:

- Congress should take action to correct these payment shortfalls within the Medicare program by including low-volume adjustments to the Prospective Payment System that calculates payments for tweener as well as rural referral hospitals.

6. Preservation of Critical Access Hospital Program

The nation's Critical Access Hospital (CAH) program has been extremely beneficial to preserving access to health care, especially in rural areas like many in Iowa. Iowa's 82 CAH hospitals have excellent records of service and the program should remain intact as well as current funding and payment methods for CAHs within the Medicare (and Medicaid) programs.

Action Needed:

- Any efforts to change or eliminate the CAH program should be resisted.

7. Challenges to Hospitals' Tax-Exempt Status/Charity Care Mandates

The Finance Committees "Financing" options paper included a section that would attempt to "codify organizational and operational requirements for determining whether a hospital is a charitable organization for the purposed of tax-exempt status."

This approach would try and put into place a one-size-fits-all approach for community benefits, would standardize these requirements on a nationwide basis and would institute financial penalties for hospitals found to be in non-compliance.

Hospitals are committed to tailoring community benefit programs to serve the needs of communities they serve. To institute a blanket approach to community benefits would not be an appropriate measure because it would not accurately reflect the benefits that the community is actually receiving.

Action Needed:

- Hospitals need the flexibility to develop community benefit programs by working with their communities' needs as they have a long history of doing. Any attempts to legislate community benefit mandates should be resisted.
- Requiring hospitals to provide a minimum amount of charity care ignores the other valuable community benefits that hospitals provide to their communities and may incidentally reduce the resources available for community outreach. Congress' efforts would be better suited trying to reduce the number of uninsured Americans, thereby reducing the amount of charity care hospitals have to provide.