Federal Issue Talking Points

Site Neutral Payments: The budget agreement passed in 2015 equalizes payment rates between new off-campus provider-based hospital outpatient departments (HOPDs) and physician offices, despite evidence that these settings have different patient populations, regulatory requirements and cost structures. Yet some policymakers, including the Medicare Payment Advisory Commission (MedPAC), have advocated for even greater use of such "site-neutral" payments and want to make total payment for a service provided in a hospital the same as when a service is provided in a physician office or ambulatory surgery center (ASC).

Why it is important: Hospitals are not ambulatory surgical centers of physicians' offices. They provide a higher level of care and provide 24/7 access to care for all types of patients. They are safety net providers for vulnerable populations, and to have the resources needed to respond to disasters and other emergencies. These roles are built into a hospital's overall cost structure and supported by revenues received from providing direct patient care. Hospitals are also subject to more comprehensive licensing, accreditation and regulatory requirements than other settings.

Regulatory Requirements/Roles	Hospital Outpatient Department	Ambulatory Surgery Center	Physician Office
24/7 Standby Capacity for ED Services	✓		
Back up for Complications Occurring in Other Settings	✓		
Disaster Preparedness and Response	✓		
EMTALA Requirements	✓		
Uncompensated Care/Safety Net	✓		
Teaching/Graduate Medical Education	✓		
Special Capabilities (burn, trauma, neonatal, psychiatric services, etc.)	✓		
Required Government Cost Reports	✓		
Equipment Redundancy Requirements	✓		
Stringent Building Codes (ventilation systems, hallway widths, ceiling heights, etc.)	✓		
Infection Control Program	✓	✓	
Quality Assurance Program	✓	✓	
Joint Commission Accreditation	✓	✓	
Life and Fire Safety Codes	✓	✓	✓
Malpractice Insurance	✓	✓	✓
Admin Staff/Billing	✓	✓	✓
Medical Supplies	✓	✓	✓
Nurses	✓	✓	✓
Space and Utilities	✓	✓	✓

Position: The Arkansas Hospital Association supports Congressional actions to protect HOPDs under development and rejects calls for any additional site-neutral payment policies. We also will urge CMS to implement the existing cut in the most favorable and flexible manner possible.

Federal Issue Talking Points

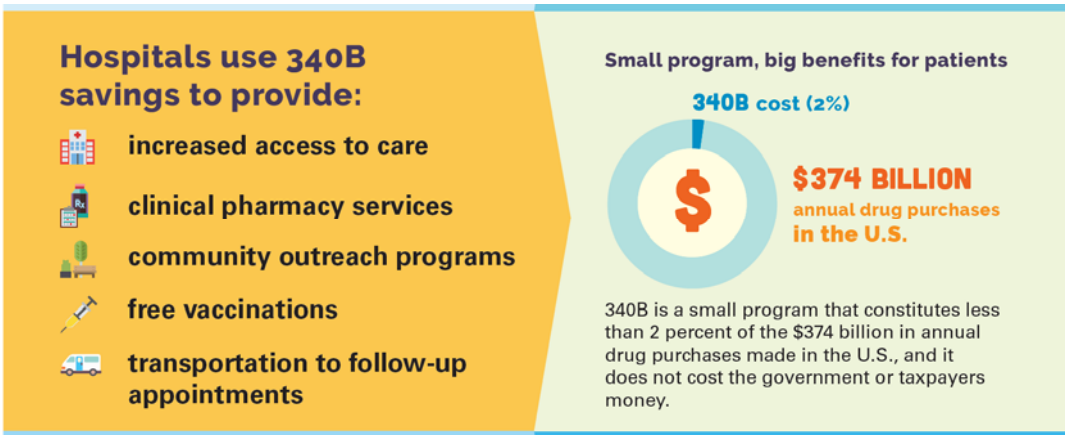
340B Drug Pricing Program: Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in the Medicaid drug rebate program to sell outpatient drugs at discounted prices to taxpayer-supported healthcare facilities that care for uninsured and low-income people.

Why it is important: The program, which was set up in 1990, enables eligible entities such as hospitals and community health centers, to purchase pharmaceuticals for outpatients at the manufacturers' "best price," stretching scarce resources and enabling those providers to provide services to more patients.

The program allows these hospitals to combat the rapidly rising cost of prescription drugs through average savings of 25%-50% on their pharmaceutical spending for outpatients. Extending the 340B discounts to the purchases of drugs used during inpatient hospital stays and expanding the program to certain rural hospitals would save hospitals more.

In addition, because the program generates savings for the federal and state governments by requiring hospitals to rebate Medicaid a percentage of their savings on inpatient drugs administered to Medicaid patients, the Congressional Budget Office estimates that expanding the program to cover inpatient services would save the federal government upwards of $1.2 billion.

The Pharmaceutical Research and Manufacturers of America (PhRMA) seems to be the only group opposed to the 340B program. However, some members of Congress want to scale back the program or significantly reduce the benefits eligible hospitals and their patients receive from the program.



Position: The Arkansas Hospital Association opposes efforts to scale back or significantly reduce the benefits of the 340B program and supports extending the 340B discounts to the purchases of drugs used during inpatient hospital stays and expanding the program to certain rural hospitals.

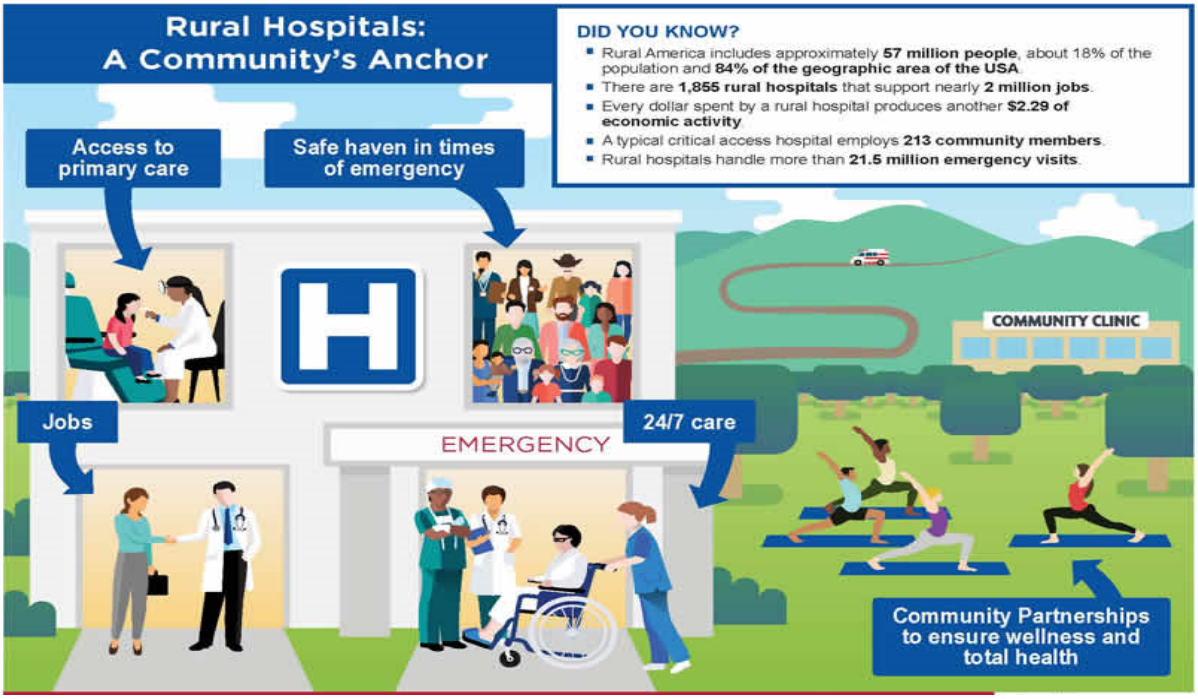
Federal Issue Talking Points

Medicare rural payment extensions: Medicare rules include a number of important payment policies that ensure financial stability for hospitals that primarily treat Medicare patients, account for low patient volumes, and address the high costs of providing ambulance services in rural areas.

Why it is important: Without legislative action, these programs will expire in 2017:

- Medicare-dependent hospitals (MDH);
- Enhanced low-volume adjustment; and
- Add-on payments for ambulance services in rural areas.

Finally, small, rural hospitals need continued relief from onerous supervision requirements that threaten access to outpatient therapy services.



Position: The Arkansas Hospital Association supports extending regulatory relief to rural hospitals by passing the:

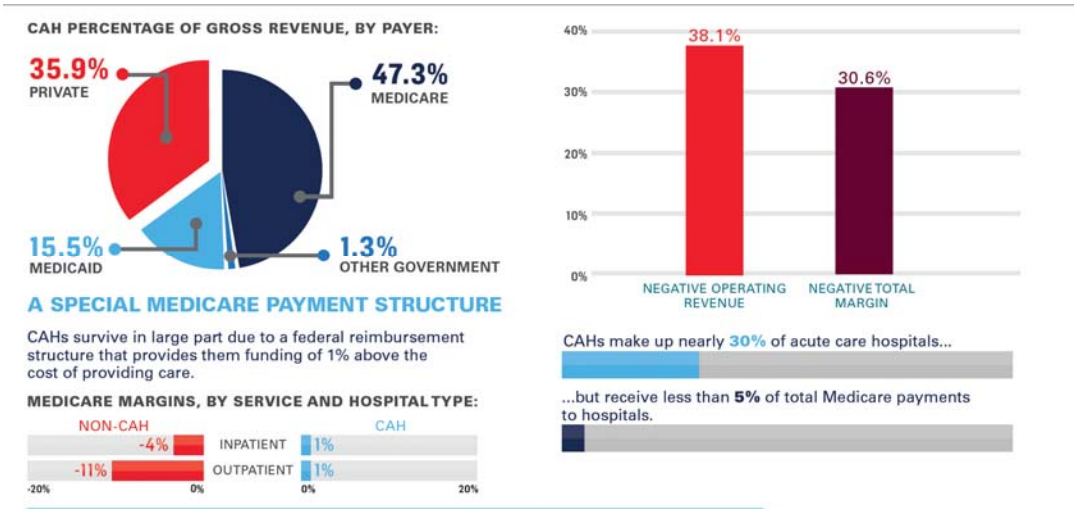
- Rural Hospital Access Act (S. 332, H.R. 663), which would make the MDH program and low-volume adjustment programs permanent.
- Medicare Ambulance Access, Fraud Prevention, and Reform Act (S. 377, H.R. 745), which would make the ambulance add-on payments permanent.
- Rural Community Hospital Demonstration Extension Act (S. 607, H.R. 672), which would extend the RCH demonstration for five years.
- Protecting Access to Rural Therapy Services Act (S.257, H.R. 1611), which would protect access to outpatient therapeutic services.

Federal Issue Talking Points

CAH payment policies: 1,330 Critical Access Hospitals (CAHs) provide essential medical care to rural communities across 45 states. Arkansas has 29 CAHs. Each CAH maintains 25 or fewer beds, but they create a significant impact on those local economies to the local economy. CAHs make up about 30% of all community hospitals, but consume only 5% of Medicare payments to hospitals. Yet, some policymakers are calling for dramatic changes to the CAH program.

Why it is important: While their health care services have bolstered rural areas, their small size means that CAHs can only focus on providing the most essential medical services, in contrast to higher volume hospitals that have more resources and flexibility to offer a wider range of services. It also worsens their fragile financial situations.

More than 60% of CAH revenue comes from government payers, which means that any payment reductions to Medicare or Medicaid, like the 2% Medicare sequestration reduction, have an immense impact on CAHs' ability to provide access to beneficiaries in rural communities. And, although Medicare pays CAHs 1% above the cost of providing care (less the 2% sequestration now), revenues from other payers often don't cover costs, illustrating why adequate Medicare payments must continue in order for CAHs to be able to provide care for rural populations.

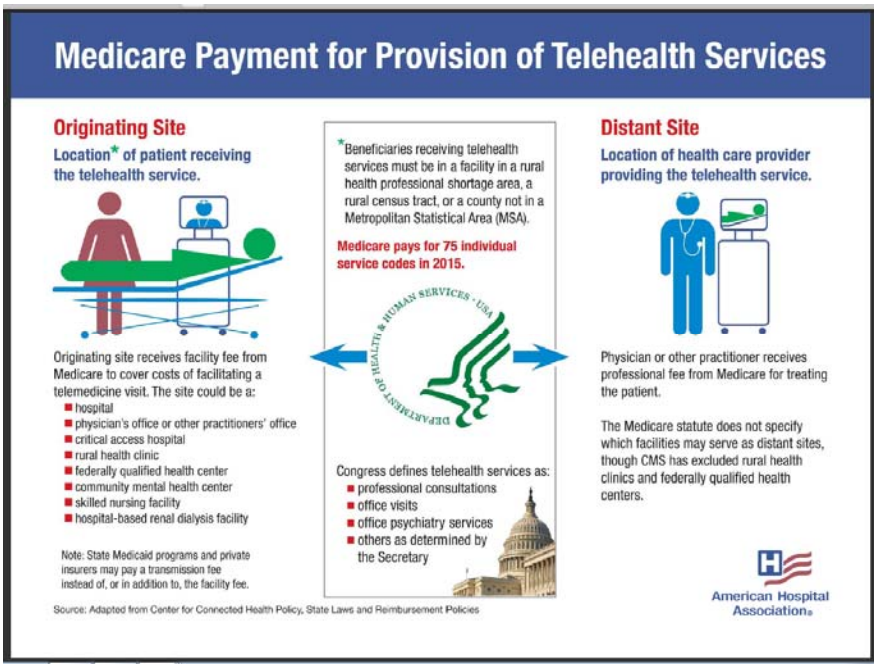


Position: The Arkansas Hospital Association (AHA) will oppose any proposal to change the CAH program. In addition, AHA supports the *Critical Access Hospital Relief Act* (S. 258, H.R. 169), which would remove the 96-hour piece of the physician certification requirement as a condition of CAH Medicare payment.

Federal Issue Talking Points

Telehealth: Recent years have seen significant growth in use of telehealth, to the point where more than half of U.S. hospitals connect with patients and consulting practitioners through the use of video and other technology. However, coverage, payment and other policy issues prevent full use of telehealth, remote patient monitoring and similar technologies. Medicare policy is particularly challenging, as it limits the geographic and practice settings where beneficiaries may receive services, as well as the types of services that may be provided via telehealth and the types of technology that may be used. Access to broadband services and state-level policy issues, such as licensure, also limit the ability to use broadband.

Why it is important: From emergency department care to remote patient monitoring for chronic care management and access to care from specialists, telehealth is changing the way healthcare is provided – both expanding patient access to routine and specialty care while improving patient satisfaction and outcomes. More than 65% of hospitals have implemented telehealth services resulting in expanded access to care, improved quality and patient satisfaction, and cost savings. But, Medicare payment policies lag behind.



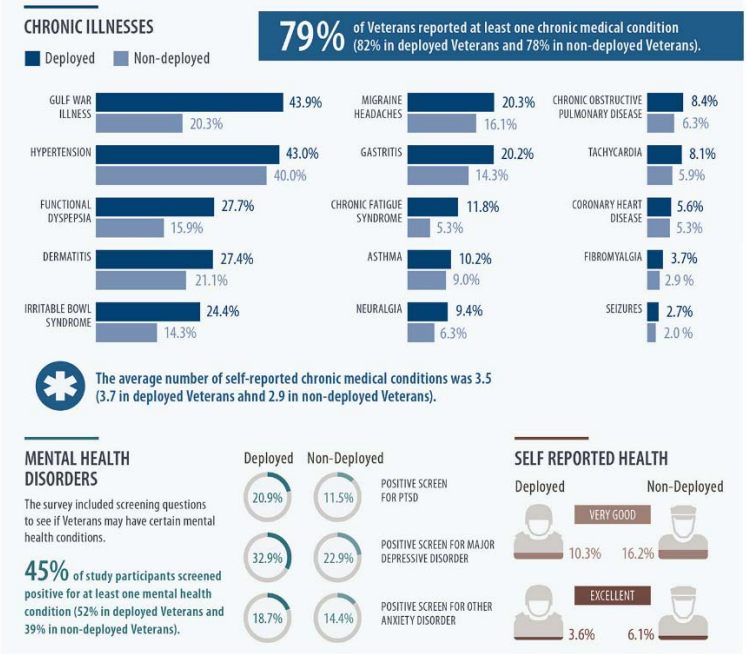
Position: The Arkansas Hospital Association supports expanding Medicare coverage and payment for telehealth and provisions for additional study of the cost-benefit of telehealth.

Federal Issue Talking Points

VA payments to non-VA hospitals: America's hospitals have a long-standing history of collaboration with the Veterans Administration. They embrace a duty and responsibility to serve U.S. military veterans who are unable to obtain timely care at VA healthcare facilities. However, the VA also has a responsibility, which they successfully avoid via a frustrating billing/payment process that results in relatively low, slow and often no payments to hospitals for the care they provide to veterans.

Why it is important: In November 2014, 60 Arkansas hospitals reported more than 4,400 claims for services provided to veterans – many dating back more than three years – totaling $24 million were unpaid. In March 2015, the VA reported a national backlog of more than $878 million in delayed payments for veterans' emergency medical services delivered by non-VA providers and acknowledges that delayed payments and inappropriately billed claims are unacceptable and have caused stress for Veterans and providers alike.

Despite recent changes to the Veterans Choice Program, there has been little improvement. Medical records are routinely lost or unaccounted for, leading to questions of privacy for our veterans; rules governing payment for care provided to veterans in non-VA facilities are side-stepped; and there is limited oversight of how these claims are processed.



Position: The Arkansas Hospital Association supports additional legislation and/or broader congressional oversight to better ensure the VA pays for care provided to veterans in non-VA facilities.