



Key Messages for the Minnesota Congressional Delegation January 2012

Ongoing Budget Concerns

Minnesota hospitals and health systems oppose any further reductions to payments for hospital services under Medicare and Medicaid for the following reasons:

- The hospital field is already absorbing \$155 billion in reductions as a part of the Affordable Care Act.
- Federal programs already pay Minnesota hospitals less than the actual costs of caring for patients. In 2010 Medicare and Medicaid underfunding to Minnesota hospitals exceeded \$1.3 billion, or nearly 7 percent of hospitals' operating expenses.
- As Minnesota struggles to balance its budget, policymakers have repeatedly turned to the safety net of the Medicaid program for savings. Minnesota hospitals now face another 10-percent cut in Medicaid payments, putting the formula for calculating inpatient reimbursement rates at hospitals 2002 costs minus 26 percent.
- Cuts to graduate medical education would jeopardize the ability of teaching hospitals to train the next generation of health care providers. Minnesota hospitals already face a 45-percent funding reduction to Medical Education and Research Costs while the nation prepares for a critical shortage of health care professionals, the effects of an aging population and 32 million newly insured individuals by 2014.
- Minnesota's 79 Critical Access Hospitals (CAHs) face unique challenges. Because of their rural settings CAHs often operate with modest balance sheets; have more difficulty accessing capital to invest in new equipment, install electronic medical records and renovate aged facilities; and struggle to recruit physicians and caregivers.
- Congress has been considering cuts to outpatient and evaluation management services (E/M) — some of the most common outpatient services provided in hospitals. The Minnesota Hospital Association (MHA) opposes these cuts because hospital outpatient departments treat sicker patients than physician offices; have higher cost structures because of the need to have emergency capacity; and have to comply with more complex regulatory requirements.
- Medicare bad debt payments are essential to help hospitals care for low-income patients. Hospitals make a reasonable effort to collect unpaid deductibles and coinsurance; however most Medicare beneficiaries have modest incomes. Medicare already pays hospitals less than the cost of delivering a service and hospitals may be forced to cut essential services for Medicare beneficiaries if bad debt payments are reduced.

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Community Benefit

Minnesota hospitals and health systems constantly demonstrate their spirit of caring beyond the hospital walls.

- Minnesota hospitals and health systems spent about \$3.4 billion on community contributions in 2010 — an increase of almost 6 percent compared to 2009.
- The overall increase was fueled by a double-digit growth in charity care — a 27 percent increase from 2009 to 2010.
- About \$1.2 billion was used to support education and workforce development; research; community building activities; donations to other community groups; and public health and outreach programs such as smoking cessation services, health screenings and immunization clinics.

Accountable Care Organizations (ACOs)

Minnesota hospitals and health systems continue our proud traditions of innovation, and delivering high quality care at lower cost.

- Park Nicollet Health Services; Allina Hospitals and Clinics; and Fairview Health Services have each been designated as Pioneer ACOs.
- Only 18 states have health care providers participating in the new ACO program. Minnesota is proud to be home to three of the 32 participating organizations.
- Only two states (California and Massachusetts) have more Pioneer ACOs than Minnesota.

Physician Supervision for Outpatient Services Concerns

Minnesota hospitals continue to be concerned about onerous physician supervision requirements for outpatient therapeutic services called for by CMS.

- MHA submitted a request to present our proposed solution to the CMS Advisory Panel on Hospital Outpatient Payment at its first meeting this February. Our request is pending.
- MHA supports a solution that would clarify the policy to be a default requirement to provide general supervision with enumerated exceptions for high-risk, complex therapies based on clinical data and evidence.

Adverse Event Report Release

On Jan. 19, the Minnesota Department of Health released its eighth annual Adverse Health Events Report. Minnesota was the first state to publicly report adverse health events by hospital in 2003. Today, Minnesota hospitals and the state health department remain committed to this high level of transparency because it improves our care of patients.

- This year's report found an increase in the number of medical errors reported over last year, from 305 events in 2010 to 316 in 2011. The report shows the lowest level of harm to patients since 2007, when the categories of what we report expanded. The report shows a total of five deaths associated with medical errors, down from ten the year before.
- This year's increase of events is mostly from two categories; pressure ulcers and wrong procedures. This is result of Minnesota hospitals diligently looking in new areas to identify and prevent these types of events.
- Minnesota hospitals have made great strides in patient safety since reporting began in 2003. In 2011 Minnesota hospitals reported fewer deaths, fewer falls, fewer wrong-site surgeries and no sponges left in mothers during labor and delivery.