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2015 Advocacy Agenda

Transforming the Health Care Delivery System

- Implementing New Health Care Delivery System Models
- Improving Health Care Quality, Safety and the Patient Experience of Care
- Expanding Health Coverage and Access
- Maximizing Health Information Technology to Improve Care
- Building the Health Care Workforce of the Future
- Streamlining Quality Measurement and Pay-for-Performance
- Eliminating Barriers to Care Coordination
- Reforming Program Integrity Efforts to Improve Accuracy, Fairness and Transparency
- Expanding Medical Liability Reform
- Promoting Hospital Price Transparency

Maintaining Essential Resources

- Oppose Reductions to Payments for Hospital Outpatient Services
- Reject Proposals to Equalize Payments for Inpatient Rehabilitation Hospitals and Units and Skilled Nursing Facilities for Certain Services
- Reject Payment Reductions to Long-term Care Hospitals
- Reject Reductions to Payments for Graduate Medical Education
- Maintain Support for Small and/or Rural Hospitals
- Reject Reductions to Assistance to Low-income Medicare Beneficiaries (Bad Debt)
- Oppose Further Restrictions on Medicaid Provider Assessments
- Provide Resources to Support Emergency Preparedness and Response Capabilities
- Preserve Existing Restrictions on Physician Self-referral to Physician-owned Hospitals
- Reject Harmful Restrictions on the 340B Drug Pricing Program

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Implementing New Health Care Delivery System Models

AHA View

The AHA supports accelerating the development and use of alternative payment and delivery models to reward better, more efficient, coordinated and seamless care for patients. Hospitals should be encouraged to adopt these models through an appropriate balance of risk and rewards, rather than through use of penalties – an approach that uses more "carrots" than "sticks." In addition, there must be incentives in place to motivate patients to engage actively in their own care. Payers must ensure predictability and stability in payments while hospitals build the infrastructure necessary to redesign care. At the same time, they must share more accurate and timely data with providers. Finally, the federal government should refrain from changing the rules governing these programs mid-stream, remove regulatory barriers and provide increased flexibility to allow hospitals to manage care successfully in these new models.

Background

Many hospitals, health systems and payers are adopting delivery system reforms with the goal of better aligning provider incentives to achieve the Triple Aim of improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of health care. These reforms include forming accountable care organizations (ACOs), bundling services and payments for episodes of care, developing new incentives to engage physicians in improving quality and efficiency, and testing payment alternatives for vulnerable populations. Private payers and large employers are working with hospitals and health systems to pursue these models, as is the federal government. Specifically, in early 2015, Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell announced a goal of 30 percent of fee-for-service (FFS) Medicare payments being tied to alternative payment models, such as ACOs, by the end of 2016 and to increase that amount to 50 percent of FFS payments by 2018.

Key Priorities

The AHA is working with its members to help test and adopt new payment systems and models of care. These include:

- Establishing ACOs, where appropriate;
- Testing bundled payments;
- Participating in Center for Medicare & Medicaid Innovation (CMMI) demonstration projects;
- Engaging in Medicaid delivery system reform; and
- Enhancing population health.

Establishing ACOs

ACOs are groups of physicians, hospitals and other health care providers who come together to better coordinate care to improve quality and reduce cost. Medicare ACOs were a key delivery system reform initiative included in the

Affordable Care Act (ACA), though some hospitals have been participating in similar arrangements with private payers for several years. The Centers for Medicare & Medicaid Services (CMS), in collaboration with CMMI, operates two major Medicare ACO programs: the Medicare Shared Savings Program (MSSP) and the Pioneer ACO program. In addition, CMMI has developed two programs, the Advanced Payment ACO and the ACO Investment Model, to help small and rural providers with the up-front costs of participating in the MSSP. According to CMS, as of Jan. 1, 2015, there are more than 420 Medicare ACOs in operation, serving more than 7.8 million program beneficiaries.

While hospitals and health systems are committed to the concept of accountable care, the AHA continues to have significant concerns about the design of the Pioneer and MSSP ACO models. The programs place too much risk and burden on providers with too little opportunity for reward in the form of shared savings. In December 2014, CMS proposed revisions to the MSSP intended to encourage continued and enhanced participation in the program and reduce administrative burden for participating ACOs. Though some of CMS's proposals could make the program more attractive to new applicants and existing ACOs, the AHA has urged CMS to move the program away from using penalties rather than rewards to encourage ACOs to accept greater risk.

In March 2015, CMMI announced a new model, the Next Generation ACO, for ACOs that are ready to accept advanced risk. Whereas the existing ACO models are essentially based on a FFS structure, this new model will include an option in later years for ACOs to receive a population-based or capitated payment. In addition, the Next Generation model will include incentives to encourage beneficiaries to seek care within their ACO network. This model also will remove regulatory barriers to allow ACOs to better manage and coordinate care. The AHA will continue to press CMS to eliminate those barriers for participants in all ACO models.

Additionally, the AHA continues to work with the HHS Office of Inspector General, the Department of Justice, the Federal Trade Commission and the Internal Revenue Service on the legal issues around establishment of ACOs and to better facilitate clinical integration. To learn more about efforts around clinical integration, see the AHA's March 2014 *TrendWatch*, "The Value of Provider Integration."

Testing Bundled Payments

Bundled payments reimburse providers a set fee for an episode of care and have the potential to promote higher quality and better coordinated care at a lower cost. Bundling is being tested in both private and public insurance markets. The largest effort is the CMS-CMMI Bundled Payments for Care Improvement (BPCI) initiative. CMS has identified 48 conditions for testing under the initiative, and the associated diagnosis-related groups (DRGs) encompassed by these conditions account for about 70 percent of Medicare admissions.

BPCI participants are testing four bundled payment models:

- Model 1 includes only inpatient hospitalization services for targeted Medicare-severity DRGs (MS-DRGs). Medicare pays participants traditional FFS payment rates, less a negotiated discount. Physicians are paid separately. In the hopes that hospitals and physicians will better coordinate care, participants may share in gains from care redesign.
- Model 2 includes the inpatient hospitalization, physician and related post-discharge services for 30, 60 or 90 days post-discharge. Medicare pays participants their "expected" Medicare payments, less a negotiated discount. Participants keep any savings achieved on bundled services.
- Model 3 includes only post-discharge services. Payments are made as in Model 2.
- Model 4 includes inpatient hospitalization, physician and related readmission services. Medicare pays participants a prospectively determined amount.

There has been significant interest in the program, with 870 entities representing more than 6,400 providers, including hospitals, physician group practices and post-acute care providers, participating in the exploratory phase of the BCPI. However, only 105 entities, representing 243 providers, have signed on to move into the risk-bearing phase. The remaining providers have until Oct. 1, 2015 to take on risk or leave the program.

The AHA has conducted extensive data analysis to help hospitals better understand the intricacies of a bundled payment system. (Refer to the AHA policy issue brief, "Moving Towards Bundled Payment," for more information.) Chief among the issues addressed include considerations for:

- Identifying which episodes are well-suited to payment bundling based on their prevalence and cost, the level of variation in program payment and the availability of evidence-based care guidelines;
- Developing the case for risk-adjustment for factors that cause substantial variation in episode payments, such as beneficiary demographic and clinical characteristics, and facility characteristics; and
- Patient placement at discharge affecting episode costs.

The AHA supports bundled payment, including a post-acute bundle, but much work is still needed to ensure that bundling is workable for patients and providers, including monitoring the BCPI initiative and evaluating the results.

Participating in CMMI Demonstration Projects

CMMI was created by the ACA to serve as a vehicle for transforming the delivery and payment of health care services by testing innovative payment and service

delivery models to reduce program expenditures while preserving or enhancing quality. Its budget is $10 billion for activities from fiscal years (FYs) 2011 through 2019, and $10 billion for each subsequent 10-year fiscal period beginning with FY 2020.

CMMI has focused its efforts around three core strategies: improving the way providers are paid; improving the way care is delivered; and increasing the availability of information to guide decision-making. Its initiatives fall into the following categories (including examples):

- Primary care transformation (Comprehensive Primary Care Initiative; Federally Qualified Health Center Advanced Primary Care Practice Demonstration)
- Accountable Care (Pioneer ACO, Advanced Payment ACO, Comprehensive End-Stage Renal Disease Care Model)
- BCPI
- Initiatives focused on Medicaid and the Children's Health Insurance Program (CHIP) populations (Strong Start for Mothers and Newborns)
- Initiatives focused on Medicare-Medicaid enrollees (Financial Alignment Initiative, Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents)
- Initiatives to speed the adoption of best practices (Partnership for Patients, Million Hearts)
- Initiatives to accelerate the development and testing of new payment and service delivery models (Health Care Innovation Awards, State Innovation Models)

All 50 states and the District of Columbia have at least one payment or delivery system reform model being run at the state level, in addition to innovations being tested by health care facilities. As of the end of FY 2014, CMMI had launched 22 payment and service delivery initiatives. The agency estimated that, as of that time, more than 60,000 providers were participating in these initiatives, furnishing care to more than 2.5 million Medicare, Medicaid and CHIP beneficiaries. The agency also has worked to engage other payers in testing these models in order to align financial incentives across payers when possible.

Engaging in Medicaid Delivery System Reform

Many state Medicaid programs are engaging in testing delivery system reform models. Though most states have turned to managed care for their Medicaid populations, a significant number also administer primary care case management programs. In addition, state Medicaid programs are implementing patient-centered medical homes, health homes for patients with chronic conditions and ACOs.

Seven states have used Section 1115 demonstration waivers to create delivery system reform incentive payment programs. These programs reallocate Medicaid supplemental funding pools that were previously used to reimburse hospitals for uncompensated care. Instead, the funds are used to make payments to hospitals to encourage them to implement delivery system and payment reform projects.

Enhancing the Health of Populations

As the U.S. health care system transforms, hospitals are expanding their work to support the Triple Aim by improving the health of their patients and surrounding communities. The ultimate goal is to improve the overall health of a given population while also reducing health disparities. Achieving improved population health will ultimately decrease medical costs.

Hospitals have long focused on providing high quality clinical care to their patients. More recently, they have invested in efforts that go beyond direct clinical care – such as care coordination and prevention – to improve outcomes for the populations they serve. In addition, hospitals are engaging in traditional public health initiatives to improve the overall health of their communities. For example, hospitals may provide free clinics, housing support for the homeless, meals on wheels to community residents, literacy programs or farmers' markets.

The AHA published two guides, "Managing Population Health: The Hospital's Role" and "The Role of Small and Rural Hospitals and Care Systems in Effective Population Health Partnerships," which outline how population health can serve as a strategic platform to improve health outcomes. Both are available at *www.hpoe.org*.

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Improving Health Care Quality, Safety and the Patient Experience of Care

AHA View

Hospitals and health systems are working to achieve the Triple Aim – improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of health care. They are integrating with other providers in a variety of ways to ensure more coordinated and patient-centered care and eliminate unneeded expenditures. They are dramatically reducing preventable infections and complications associated with adverse drug events, catheter-associated urinary tract infections (CAUTI), central line-associated blood stream infections, injuries from falls, ventilator-associated pneumonia and other adverse events. At the same time, policymakers need to reform how they oversee, regulate and stimulate change in the health care delivery system. They need to understand how their rules, measures and actions affect the activities of caregivers on the front line so they are not creating confusion or derailing successful improvement activities with discordant or outdated approaches to regulation. This is best achieved when there is open dialogue and opportunities for discussion among affected stakeholders.

Background

Hospitals engage in an array of collaborative activities designed to improve the quality and safety of the care they provide. The increasing amount of credible and actionable information that has become available through public reporting efforts has helped spur improvements. While it is worth celebrating the improvements in patient safety and quality, such as reductions in hospital-acquired infections and early elective deliveries, it also is imperative that hospitals continue to strive for better performance. Public policies can further facilitate or impede hospitals' efforts to improve quality, which is why the AHA and its member hospitals work closely with the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention, Food and Drug Administration, Agency for Healthcare Research and Quality, the National Quality Forum, The Joint Commission and other national accreditation bodies. As hospitals and health systems continue to look for ways to advance quality of care while lowering costs, the AHA has taken a leadership role in supplying information to hospitals to help them further improve the work they do.

A summary of hospitals' ongoing progress in improving care is available at *www.aha.org/qualitycompendium*.

Key Priorities

The AHA will continue to work with members, the federal agencies and other stakeholders to improve the quality and safety of health care. This includes:

- Disseminating successful practices;
- Promoting equitable care; and
- Championing the appropriate use of medical resources.

Disseminating Successful Practices

AHA/Health Research & Educational Trust (HRET) Hospital Engagement Network (HEN). HRET, an AHA affiliate, was awarded a contract by CMS to support the Partnership for Patients campaign, a three-year, public-private partnership designed to help improve the quality, safety and affordability of health care for all Americans. The project helped hospitals adopt new practices with the goal of reducing inpatient harm by 40 percent and readmissions by 20 percent. The project, which included a network of nearly 1,500 hospitals across 31 states, focused on several areas of impact. During the project, an estimated 92,000 harms were avoided with a projected cost savings of $988 million. Some additional highlights include a:

- 61 percent reduction in early elective deliveries across 800 birthing hospitals;
- 48 percent reduction in Venous thromboembolism (VTE) across 900 hospitals of all types (acute/critical access/rural); and
- 54 percent reduction in pressure ulcers across 1,200 hospitals.

CMS recently announced phase two of the partnership, set to begin later this year.

Comprehensive Unit-based Safety Program (CUSP). HRET also works closely with several partners to fund national quality improvement efforts. Using CUSP, a customizable program that helps hospital units address the foundation of how clinical teams care for patients, participating hospitals in the inpatient initiative experienced a:

- 14 percent relative reduction in CAUTI rate per 1,000 catheter days;
- 6 percent relative reduction in ICU participants; and
- 24 percent relative reduction in non-ICU participants.

These successes are changing the way the health care field addresses patient safety and *On the CUSP: Stop CAUTI* is expanding its work into an emergency department collaborative and a long-term care initiative.

To further these national efforts, HRET is training and helping to build a network of experts and leaders to advance the knowledge gleaned through efforts to reduce infections. Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) is an evidence-based set of teamwork tools aimed at optimizing patient outcomes by improving communication and teamwork skills among health care professionals. In 2014, more than 1,600 professionals were trained, with 96 percent saying they would make some change in their practice.

Professional Education. In addition, the AHA-National Patient Safety Foundation Comprehensive Patient Safety Leadership Fellowship, the Health

Care Transformation Fellowship and HRET senior fellows each year provide dozens of leaders the resources and guidance needed to promote and expand measurable patient safety improvements and quality transformations in hospitals, academic medical centers and state hospital associations.

A forum of the AHA, the Symposium for Leaders in Healthcare Quality (SLHQ) is a community of health care professionals whose work is focused on performance improvement in support of the Institute of Medicine aims of providing care that is safe, timely, effective, efficient, equitable and patient centered. SLHQ was created to address this challenge through building a network of engaged leaders who can advance and strengthen the achievements of many seemingly disparate improvement projects. SLHQ leverages lessons learned across these many projects to build an infrastructure for current and future improvement projects that will enhance the capacity and ability for success and provides a space for professionals to learn and connect with one another in pursuit of a common goal.

Hospitals in Pursuit of Excellence (HPOE). The AHA's strategic platform to accelerate performance improvement in health care provides education on successful practices; develops evidence-based tools and guides; provides leadership development through fellowships and networks; and engages hospitals in national improvement projects. Working in collaboration with allied hospital associations and national partners, HPOE synthesizes and disseminates knowledge, shares proven practices and spreads innovation to support care improvement at the local level.

Promoting Equitable Care

The AHA has joined four leading health organizations in *Equity of Care*, a national call to action to eliminate health care disparities and improve quality of care for every patient. The *Equity of Care* initiative focuses on three areas:

- Increasing the collection and use of race, ethnicity, and language preference data;
- Increasing cultural competency training; and
- Increasing diversity in governance and leadership.

AHA's efforts include disseminating free resources and sharing best practices on the *Equity of Care* website, *www.equityofcare.org*. To help hospitals measure and thereby effectively address disparities, HRET developed a Disparities Toolkit that enables hospitals to collect race, ethnicity and primary language data in a uniform way. The toolkit is continually reviewed to reflect Affordable Care Act requirements and The Joint Commission standards. In addition, the AHA's Center for Healthcare Governance and Institute for Diversity in Health Management developed a trustee training program to help hospitals expand the racial and ethnic diversity of their governing boards.

Championing the Appropriate Use of Medical Resources
The AHA's Committee on Clinical Leadership closely examined the appropriate use of medical resources and developed a white paper identifying drivers of health care utilization and recommended a "top five" list of hospital-based procedures or interventions that should be reviewed and discussed by a patient and physician prior to proceeding.

For each of the five procedures or interventions below, AHA is releasing toolkits highlighting best practices with resources for hospital and health systems, clinicians and patients and their families:

- Appropriate blood management in inpatient services
- Appropriate antimicrobial stewardship
- Reducing inpatient admissions for ambulatory-sensitive conditions (i.e., low back pain, asthma, uncomplicated pneumonia)
- Appropriate use of elective percutaneous coronary intervention
- Appropriate use of the ICU for imminently terminal illness (including encouraging early intervention and discussion about priorities for medical care in the context of progressive disease)

Better decision-making leads to higher quality care. Similarly, involving patients in their care decisions can improve their satisfaction and lead to improved outcomes. As one of the more intense resource users, hospitals have a responsibility to look for ways to guide appropriate and consistent use of health care and provide tools for health care providers to better communicate with patients about appropriate care.

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Expanding Health Coverage and Access

AHA View

Universal health care coverage is key to achieving the AHA's vision of healthy communities where all individuals reach their highest potential for health. To achieve this goal, the AHA has long advocated for the expansion of coverage through private and public-sector means. In addition, AHA continues its efforts to work with a broad spectrum of stakeholders, as well as the state hospital associations and member hospitals, to provide resources and tools to help connect patients and their families with affordable coverage and access to quality care.

Background

Five years after the enactment of the Affordable Care Act (ACA), the Department of Health and Human Services (HHS) reports that 16.4 million uninsured people have gained health insurance coverage. Coverage gains came through the Health Insurance Marketplaces, Medicaid and the Children's Health Insurance Program (CHIP), and through policies allowing children to stay on their parents' plan until age 26. According to HHS, the uninsured rate dropped from 20.3 percent to 13.2 percent between October 2013 (the start of the first open enrollment period) and March 2015 (the end of the second open enrollment period). This represents a gain in health coverage for 14.1 million individuals during that time. While the recent numbers point to continued improvements in health insurance coverage, several threats – legal and legislative – remain to achieving universal coverage.

Key Priorities

The AHA will continue to work on several fronts to protect and expand health care coverage and access to health care services, including:

- Maintaining health insurance subsidies for low-income individuals;
- Expanding Medicaid coverage for low-income adults;
- Maintaining CHIP funding for low-income children;
- Supporting supplemental hospital payment programs such as Medicaid Disproportionate Share Hospital (DSH) payments for hospitals that serve low-income and uninsured patients;
- Ensuring access to providers and services through adequate provider network standards; and
- Maintaining access to Medicare Advantage (MA) plans for enrollees.

Maintaining Subsidies for Low-income Individuals

The ACA currently provides financial help to low-income individuals purchasing health care coverage through the state or federal Health Insurance Marketplaces in the form of premium tax credits, commonly known as subsidies, and cost-sharing assistance. The ACA's subsidies have made it possible for more than 9 million men, women and children to obtain health care coverage with financial help. But their continued availability is in jeopardy in states that have not set up their own marketplaces. The U.S. Supreme Court in late June will rule on a case (*King v. Burwell*) challenging the permissibility of those subsidies for individuals purchasing insurance through the federally-facilitated Marketplace, known as Healthcare.gov. The AHA filed a friend-of-the-court brief supporting the

government's interpretation of the ACA's subsidies, emphasizing that the loss of those subsidies would be a disaster for millions of lower- and middle-income Americans. The brief was filed in collaboration with the Federation of American Hospitals, Association of American Medical Colleges and America's Essential Hospitals. In addition, the AHA is working with state hospital associations in the impacted states to develop tools and resources to ensure that coverage is protected in the wake of the *King v. Burwell* decision should the Court rule in favor of the plaintiffs.

Expanding Medicaid Coverage for Low-income Adults

By 2022, Medicaid is expected to add 13 million enrollees as a result of the ACA's coverage expansions. This is 4 million fewer than originally projected by the Congressional Budget Office (CBO) due to the U.S. Supreme Court's 2012 ruling that resulted in states having the choice to expand or not expand their Medicaid programs. To date, 28 states and the District of Columbia are expanding their programs. According to an October 2014 report from The Urban Institute, states not expanding Medicaid may miss out on more than $420 billion in federal funding between 2014 and 2022. The AHA believes it is important for all states to expand Medicaid to deliver on the ACA's promise of coverage. Expanding Medicaid coverage is good for the health of communities because the program helps millions of low-income adults, children and their families receive health care, serving as a backstop for those who have lost employment-based health care coverage and providing access to health care services to those who cannot afford private insurance. In addition, expanding Medicaid is good for employers because people who do not have ready access to health care put off care leading to higher absenteeism, while a healthy and productive workforce is good for economic development.

Maintaining CHIP Funding for Low-income Children

The ACA envisioned that CHIP would no longer be necessary because of Medicaid improvements and expansion and the subsidized family coverage in the Health Insurance Marketplaces. CHIP eligibility standards were extended by the ACA through 2019 to transition CHIP beneficiaries to either Medicaid or subsidized coverage through the Marketplaces. The ACA, however, did not extend CHIP funding, and it was set to expire at the end of fiscal year (FY) 2015. However, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, H.R. 2., extended CHIP funding for two additional years, through Sept. 30, 2017.

Supporting the Medicaid DSH program for Hospitals that Serve Low-income and Uninsured Patients

The Medicaid DSH program helps hospitals serving low-income and uninsured populations shoulder the financial burden of providing uncompensated care to these populations. The ACA cuts to the Medicaid DSH program were intended to coincide with increases in health care coverage. However, the 2012 Supreme Court decision on the ACA's Medicaid expansion has changed that trajectory resulting in fewer covered individuals. According to recent CBO projections, the ACA will expand coverage to 25 million – rather than the originally projected 32 million – individuals. In 2013, hospitals provided $46 billion in uncompensated care, underscoring the importance of supplemental programs like Medicaid DSH.

The AHA has been successful in delaying for three years the start of Medicaid DSH cuts. Most recently, the MACRA eliminated the Medicaid DSH cuts in FY 2017 and lowered the Medicaid DSH cuts in FYs 2018 through 2020.

Ensuring Access to Providers and Services through Adequate Provider Network Standards

The issue of health plan provider network adequacy and health plans' use of narrow or tiered provider networks has been raised in several different contexts: the new federal and state Health Insurance Marketplaces, the National Association of Insurance Commissioners, the MA program and non-grandfathered health plans. The AHA is actively advocating for adequate provider network standards in all of these contexts. The AHA strongly believes that patients and providers, the primary parties involved in care delivery, are best served when: 1) there is sufficient choice of providers; 2) care is easily accessible; and 3) patients and providers are certain of when care is being provided in or out of network and clearly understand their financial obligations under either scenario. Patients and their families should be protected, to the extent possible, from the financial burdens of unexpected balance billing. It is important to ensure that health plan enrollees have access to a selection of high-quality providers in or near their communities, while not inhibiting care coordination and the growth of integrated care systems, which by their nature, offer smaller networks of providers.

Maintaining Access to MA Plans for Enrollees and Providers

America's hospitals have been moving aggressively toward payment systems that reward value over volume, incentivize the integration of payment and care delivery, and place an emphasis on quality and access. To this end, many hospitals and health systems either now have a Medicare Advantage Organization (MAO), are planning to add an MAO or are looking to share risk with an MAO because MA serves a critically important population, values care integration and rewards quality and access. These hospital-based plans bolster the affordable plan choices available to Medicare beneficiaries across the country, enable beneficiaries to access high-quality providers who share common records and can coordinate their care, and offer value-added benefits and services beyond what basic Medicare covers.

A sustainable MA program is in the best interest of the 30 percent of beneficiaries who choose such plans. Medicare beneficiaries should have a selection of high-quality plans that include affordable premiums and cost sharing, and access to the value-added benefits on which MA beneficiaries have come to rely.

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Maximizing Health Information Technology to Improve Care

AHA View

The AHA has long advocated for expanding the use of health information technology (IT), specifically the rapid adoption of electronic health records (EHRs) and national interoperability standards. Shared health information will allow clinicians and patients to have the knowledge they need to promote health and make the most informed decisions about treatments. This goal will be achieved only if the federal government cuts back on regulatory burdens and provides supportive policies. In addition, technology vendors must make data sharing across platforms easier for providers and consumers. For their part, hospitals must prioritize security of their information systems against cyber attacks.

Background

Hospitals continue to deploy robust health IT systems to support improvements in clinical care, efficiency efforts and delivery system transformation. Some of these changes were motivated by the Medicare and Medicaid EHR Incentive Programs, which provided a carrot-and-stick approach of incentives and penalties for hospitals and physicians that either meet or fail to meet the federal requirements of "meaningful use." In addition to EHRs, hospitals increasingly are adopting telehealth, remote monitoring and data analytics solutions to expand the availability of care and improve coordination across care settings. While these technologies are essential for building the care system of the future, they can be expensive and unwieldy, and do not yet support the necessary level of easy information sharing expected by hospitals, other health care providers and consumers. Hospitals also are faced with a transition to the ICD-10 coding system on Oct. 1 and increased cyber threats from bad actors looking to disrupt information systems and steal data.

Key Priorities

The AHA will continue to work on several fronts to expand the use of health IT to improve health and health care. These include:

- Modifying the EHR incentive programs to include greater flexibility and improve electronic quality reporting;
- Implementing ICD-10 on Oct. 1, 2015, as planned;
- Increasing access to telehealth;
- Incorporating mobile health (mHealth);
- Improving interoperability;
- Implementing the Unique Device Identifier (UDI) in a responsible manner that enhances patient care;
- Maintaining cybersecurity; and
- Improving the safety of health IT.

Obtaining Greater Flexibility for the EHR Incentive Programs

The last Medicare EHR meaningful use incentives will be paid in 2016. Penalties under the program began in 2015 and do not sunset. About 200 hospitals are

receiving Medicare penalties in 2015, as are one of every two eligible professionals. The requirements of the program have been too prescriptive and burdensome, and hold hospitals and physicians accountable for the actions of others beyond their control. A recently released proposed rule would shorten the reporting period in 2015 to 90 days and provide flexibility on the patient portal requirements – key changes that the AHA has strongly advocated. The rule also introduces a host of other changes in the middle of the program year that could prove confusing and burdensome. At the same time, CMS has proposed new rules for Stage 3 of meaningful use that raise the bar too high once more, while lacking the flexibility hospitals need to succeed in the program and use IT to meet their own strategic goals. The AHA continues to advocate for a more reasonable timeline for the program, and greater flexibility in the requirements, building on successful advocacy efforts to increase flexibility in 2014.

Implementing ICD-10 in FY 2016

According to an AHA survey conducted in early 2015, 93 percent of hospitals are moderately to very confident that they will be able to meet the Oct. 1 start date for ICD-10, which Congress delayed by one year. Given the large investments hospitals and health systems have made in preparing for the transition to ICD-10, the AHA urges Congress to resist all calls to delay the start date yet again. A dual processing system allowing those who are not yet ready to use ICD-9 while everyone else uses ICD-10, as some have suggested, is unworkable.

Increasing Access to Telehealth

Telehealth is increasingly vital to our health care delivery system. According to AHA survey data, in 2013, 52 percent of hospitals utilized telehealth and another 10 percent were beginning the process of implementing telehealth services. As summarized in a recent AHA *TrendWatch* report, evidence is mounting that telehealth improves quality of care, expands access to needed services and meets consumer demands. The pace of technological change also makes new approaches possible, such as remote monitoring of patients and greater use of secure video visits. However, significant regulatory and legal barriers must be addressed for telehealth to fulfill its promise, including more rational approaches to physician licensure, clarity on e-prescribing and malpractice issues, and attention to how telehealth systems will be kept secure. The AHA strongly supports improvements in Medicare coverage and payment for telehealth.

Incorporating Mobile Health (mHealth)

Just as hospitals and health systems are adopting new technologies, so are consumers. Mobile health includes use of consumer-facing applications and technologies to manage personal health and promote wellness. Increasingly, health care providers, including hospitals and health systems, are supporting consumer use of such technologies and are considering ways to incorporate mHealth data into their EHRs.

Improving Interoperability
As EHR adoption increases, hospitals and health systems remain constrained by systems that cannot efficiently share data across different platforms or even across departmental systems. Systematically sharing information across settings or organizations remains a challenge. The AHA supports interoperability and is working to ensure that any new federal efforts, such as the "Interoperability Roadmap" drafted by the Office of the National Coordinator for Health IT, take into account how hospitals and physicians generate, use, share and secure health information, and the need for efficient solutions. The AHA continues to recommend the creation of a national unique patient identifier to better connect patient records so that hospitals and physicians have the best information available when providing care for each patient.

Implementing the UDI Responsibly
The AHA is pleased that, in 2013, the Food and Drug Administration (FDA) finalized a system of UDIs for medical devices that will facilitate safety recalls, support improved quality of care and improve efficiency. The AHA is working with hospitals and FDA to ensure a smooth roll-out of the UDI over the next six years, and encourage federal authorities to ensure that certified EHRs and registries support the automated capture and use of UDI. However, we have concerns about calls to require providers and payers to include the UDI on health care claims due to the large administrative burden and expense and unanswered questions about the UDI as a standard. Incorporating the UDI into EHRs and other clinical systems will bring the most benefit for patients.

Maintaining Cybersecurity
Hospitals and health systems have an obligation to keep all information systems, not just those containing protected health information, confidential and secure. In 2013, the White House issued the *Executive Order on Improving Critical Infrastructure Cybersecurity* with the goal of improving cybersecurity and reducing cyber threats to the nation's "critical infrastructure sectors," including the health care and public health sector. In 2014, the AHA created a set of member education tools to raise awareness of cybersecurity issues and risk management strategies that is available at *www.aha.org/cybersecurity*. In 2015, we will continue these efforts and work with the federal government on its priorities, such as sharing information on cyber risks.

Ensuring the Safety of Health IT
Research has shown that health IT can both improve safety and introduce new risks for patients, raising the question of what is the appropriate role for government in overseeing health IT safety. The AHA believes that steps to address safety should build on existing patient safety efforts across government programs and the private sector and address health IT as one of many factors affecting safety, rather than as a topic on its own. On a policy level, the AHA wants to ensure that federal safety oversight for health IT is nimble but sufficient to protect patient safety, and that hospitals and other providers are not exposed to liability from unsafe products.

American Hospital Association®

Building the Health Care Workforce of the Future

AHA View

A strong and engaged workforce is the lifeblood of America's hospitals. The 5 million women and men who care for patients every day demonstrate the hard work, compassion and dedication that make hospitals such a valued resource in every community. As hospitals' national advocate, the AHA advocates for workforce issues on several fronts – workplace environment, workforce supply and employee relations.

Background

The Affordable Care Act (ACA) will greatly increase the demand for caregivers, especially primary care physicians and nurses. The law has extended coverage to millions of uninsured people and requires public and private insurers to cover prevention and wellness services. To help ensure America has an adequate workforce to meet the health needs of the newly insured, the ACA offered several initiatives to increase the supply of health care workers. For example, the law provided flexible loan repayment programs for caregivers to increase the workforce pipeline of primary care physicians, nurses and other health professionals.

Key Priorities

The AHA will continue to work with the federal agencies, Congress and other stakeholders to:

- Create excellent workplace environments;
- Maintain an adequate workforce supply; and
- Foster employee relations.

Creating the Workplace Environment of the Future

Adequate numbers of competent and well-trained nurses, physicians and other health professionals are essential to address the health care needs of the aging and increasingly diverse U.S. population. The AHA takes a multi-pronged approach to address workforce issues for America's hospitals:

- **Effectively deploy a competent and engaged workforce to deliver high-quality patient care.** The current workforce and models of care will not be able to accommodate the influx of new patients. The AHA is committed to reforming the delivery of care and workforce models to support population health initiatives. The AHA's white paper, "Workforce Roles in a Redesigned Primary Care Model," makes recommendations for retuning the health care workforce to better provide primary care services.
- **Redesign clinical care at the bedside/point of care and the roles of the inter-disciplinary direct care team of providers.** Hospitals are redesigning current models of care to better address clinical care issues such as hospital-acquired conditions, readmissions and overall coordination of care. Research has demonstrated that high-reliability teams of providers are better suited to direct and manage care in the hospital setting, while also integrating patient care across care settings.

- **Create excellence in clinical work environments, and ensure an environment to facilitate workforce recruitment and retention, a safe and competent workforce and appropriate employer/employee engagement.** Work expectations are changing and competition for well-qualified employees is increasing. Health care facilities must strive to provide excellent work environments for clinicians and staff.

For additional AHA, national and state-based workforce resources, please visit *www.aha.org/workforce*.

Maintaining an Adequate Workforce Supply

The AHA continues to advocate for the highest level of appropriations for nursing and other health education programs. Although the sequester cuts to Title VIII Nursing Education programs were less than other non-defense discretionary programs, the timing could not be worse. The demand for nurses is increasing; however, meeting that demand remains difficult due to nursing faculty shortages and reduced funds for nursing scholarships and loans. The situation is compounded by the aging of the nursing workforce and the increased care burden of patients with multiple co-morbidities. Provisions in the ACA have helped modernize and expand Title VIII programs. Under the Workforce Development Programs, the authorization level for discretionary funding was raised to $338 million. Although the fiscal year 2015 appropriated funding of $231.6 million falls short of the ACA-authorized level, the higher authorization level allows for growth.

Visas. The AHA supports streamlining and improving the immigration process to allow qualified, internationally educated nurses, physicians and other health professionals to work in this country. We continue to work with Congress and the administration to improve opportunities for qualified health care professionals, including maintaining the availability of employment-based and non-immigrant visas for shortage professions.

Residency Slots. Given the current and projected shortage of physicians, especially in primary care and general surgery, the AHA continues to urge that the 1996 cap on residency slots be lifted. Limits on the number of Medicare-funded residency training slots constrain the ability of hospitals to train new physicians. The AHA is committed to working with Congress to develop legislation that would increase the number of Medicare-supported physician training programs by at least 15,000 new resident positions, a 15 percent increase in residency slots. The AHA also continues to oppose reductions to Medicare funding for graduate medical education (GME) and supports maintaining full funding for GME conducted in children's hospitals.

Fostering Employee Relations

The AHA is committed to preserving the right of individual hospitals and health care systems to determine the appropriate hospital-employee relationship for

their organizations and communities. That is why we continue to oppose certain organized labor-supported initiatives that would interfere with hospitals' ability to work directly with employees to enhance the work and patient care environments. In 2015, labor and employment activities will continue to be concentrated in various regulatory agencies and the courts. Below is a snapshot of issues.

National Labor Relations Board (NLRB). The NLRB published in the Dec. 15, 2014 *Federal Register* a final rule amending its representation-case procedures to change the process for resolving representation disputes, essentially speeding up the time between filing a petition and holding an election. The final rule is largely identical to a previous rule issued in 2011 and would, among other changes, defer resolution of most voter eligibility questions until after the election, consolidate all election-related appeals into a single post-election process, and make board review of post-election decisions discretionary rather than mandatory. The rule took effect on April 14, 2015. The AHA and two of its affiliated organizations – American Society for Healthcare Human Resources Association (ASHHRA) and American Organization of Nurse Executives – urged NLRB to withdraw the rule entirely, charging that it "single-mindedly promotes quick elections at the expense of a fair process."

The final rule is the subject of two legal challenges. The U.S. Chamber of Commerce, joined by the Coalition for a Democratic Workplace (of which the AHA is a member) and Society for Human Resource Management filed suit in the United States District Court for the District of Columbia.

Department of Labor (DOL). The DOL is expected to move forward with several regulatory initiatives affecting hospital and health care employee relations. The DOL's Office of Labor and Management Standards plans to finalize a proposal revising the interpretation of the "advice" exemption to persuader reporting under the 1959 Labor-Management Reporting and Disclosure Act. The final rule could narrow the definition of "advice" and, thus, expand circumstances under which reporting is required of employer-consultant persuader agreements. The AHA and ASHHRA oppose this proposed revision and requested that DOL decline to adopt the rule as drafted. We are concerned that the revised interpretation of the advice exemption will interfere with hospitals' ability to receive appropriate labor relations advice from outside counsel (including the AHA) that is necessary to ensure proper compliance with all applicable laws.

Despite its May 2014 announcement of a five-year enforcement moratorium, the DOL's Office of Federal Contract Compliance Programs (OFCCP) expects, ultimately, to expand the agency's regulatory and enforcement reach over hospitals, asserting that hospitals are federal contractors or subcontractors solely because of their participation in certain federally sponsored health care reimbursement programs, such as TRICARE, the Department of Defense (DoD) program that provides coverage to military personnel. During the moratorium period, the OFCCP

will not enforce federal contractor and subcontractor obligations, including obligations related to affirmative action programs and recordkeeping, on health care entities that participate in TRICARE as subcontractors under a prime contract between the DoD TRICARE Management Activity and one of the prime managed-care contractors.

OFCCP, however, plans to do extensive outreach and provide technical assistance during the moratorium period to inform TRICARE participants of their responsibilities under OFCCP's programs. In addition, during this time, OFCCP will work with other federal agencies to clarify the principles governing coverage of health care providers under federal statutes applicable to contractors and subcontractors. The agency also will continue during the moratorium period to process complaints of discrimination against TRICARE participants. That is why the AHA supports legislation to prevent OFCCP from exerting jurisdiction over hospitals and other health care organizations that provide care for uniformed service members and other federal employees and encourages reintroduction of The Protecting Health Care Providers from Increased Administrative Burdens Act.

American Hospital Association®

Streamlining Quality Measurement and Pay-for-Performance

AHA View

America's hospitals are committed to sharing meaningful, accurate hospital quality information with the patients they serve. Hospitals also support well-designed pay-for-performance programs that can help move the health care delivery system from volume to value. However, the Hospital Readmissions Reduction Program (HRRP) and the Hospital Acquired Condition (HAC) Reduction Program must be reformed to ensure hospital penalties are assessed fairly. Moreover, Medicare and other federal programs must better align and prioritize measurement efforts to address the most important issues and promote more patient-centered, effective and efficient care.

Background

More than a decade ago, hospitals initiated voluntary efforts to report quality data publicly. This data reporting was later linked to receiving a full annual payment update from Medicare through the Hospital Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) programs. The Affordable Care Act (ACA) significantly raised the financial stakes of quality measurement by introducing "pay-for-performance" programs – including the HRRP and HAC Reduction Program – that tie penalties to the level of quality performance. To date, however, HRRP penalties have disproportionately fallen on those hospitals caring for the poorest patients. Moreover, the HAC program disproportionately penalizes large and teaching hospitals caring for more complex patients and the smallest hospitals with too few patients for accurate assessment. Hospitals are overwhelmed by the sheer volume of measures they must report, and are concerned that important opportunities to improve care are being missed because the selected measures do not focus on issues that meaningfully improve care.

Key Priorities

The AHA continues to work with federal agencies, Congress and other stakeholders to help align quality reporting to improve health and health care. This includes:

- Improving the fairness of readmission penalties;
- Reforming the HAC Reduction Program; and
- Enhancing measurement alignment and focus.

Improving the Fairness of Readmission Penalties

The AHA strongly urges Congress and the Centers for Medicare & Medicaid Services (CMS) to incorporate socioeconomic adjustment into the HRRP so that hospitals caring for our nation's most vulnerable patients are not unfairly penalized. We strongly support the bipartisan, bicameral Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2015 (H.R. 1343/S. 688).

Since the HRRP's beginning, hospitals caring for the poorest patients have been significantly more likely to receive penalties. In fiscal year (FY) 2015, nearly 85 percent of hospitals in the highest quartile of disproportionate patient percentage

(DPP) received a penalty, compared to 61 percent in the lowest DPP quartile (higher DPP quartiles indicate a poorer patient population). This is because the current HRRP fails to recognize that community factors outside the control of the hospital – such as the availability of primary care, mental health services, physical therapy, easy access to medications and appropriate food, and other rehabilitative services – significantly influence the likelihood of a patient's health improving after discharge from the hospital or whether a readmission may be necessary. These community issues are reflected in readily available proxy data on socioeconomic status, such as Census-derived data on income and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. If H.R. 1343/S. 688 is passed, CMS would be required to use these data to adjust penalties, providing important relief.

The AHA also urges CMS to exclude from the HRRP readmissions unrelated to the initial reason for admission. Despite the fact that the ACA requires CMS to exclude unrelated readmissions, CMS has not fully implemented this policy. For example, a patient may be hospitalized for pneumonia, and then readmitted within 30 days for a hip fracture, which is clearly unrelated to the pneumonia. The current measures would count this readmission against the hospital.

Reforming the HAC Reduction Program

America's hospitals are deeply committed to reducing preventable patient harm. However, the HAC Reduction Program is poorly designed and imposes arbitrary, excessive penalties that disproportionately impact hospitals tending to care for the sickest patients. The AHA will work with CMS, Congress and others to improve existing policy and promote alternatives to the HAC program that more effectively promote patient safety.

The HAC Reduction Program has a number of critical flaws. First, the program's arbitrary design penalizes 25 percent of all hospitals each year, regardless of significant performance improvement, and does not measure meaningful differences in quality. Indeed, the difference in HAC scores for penalized and non-penalized hospitals in FY 2015 is hundredths of a point. Second, data show that hospitals treating complex patients are disproportionally penalized, in part because the HAC program uses claims-based patient safety indicators (PSIs) that are unreliable and do not reflect important details of a patient's risk factors and course of care. We have urged CMS to remove PSIs gradually from the HAC program. Third, some small hospitals have too few patients to have data on the two infection measures used in this program. These hospitals are assessed only on the unreliable PSIs. Finally, the HAC measures overlap with the measures in the value-based purchasing (VBP) program, yet each program uses different performance periods. This can lead to excessive payment penalties and confusion about the true state of hospital performance. To provide short-term relief, the AHA recommends that CMS use measures in either the VBP or the HAC program, but not in both.

Enhancing Measurement Alignment and Focus

The AHA continues to advocate that CMS work with multiple stakeholders to identify between five and 10 tightly-scoped, actionable priority goals for health care quality improvement on an annual basis. CMS could then select for each of its quality measurement programs a small number of reliable, accurate and care-setting-appropriate measures to ensure each relevant part of the health care system contributes to the overall goals. We believe a more focused approach will lead to even more substantial improvements in care, as has been demonstrated through the success of the AHA's work on the targeted areas of the Hospital Engagement Network that saved an estimated 92,000 instances of harm and $988 million.

To date, measurement requirements have been added without strong alignment to specific national quality priorities or goals. To add to the confusion, private payers and state regulators have adopted their own reporting requirements. As a result, the volume of measures requested of hospitals has grown so rapidly that it has created confusion about what is being measured, how it should be measured, and what the results of the measurement effort show. Hospitals spend significant resources making sense of reporting requirements that could instead be used on improving care.

To provide a starting point for identifying priorities, the AHA worked with its members to develop a list of 11 measurement concepts that hospitals believe are the highest priority to address. This list addresses multiple aspects of quality and includes issues like harm rates, patient transitions in care, risk-adjusted mortality and cost per episode. We will continue to work with all interested stakeholders to refine and encourage implementation of this focused set of measures.

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Eliminating Barriers to Care Coordination

AHA View

The Anti-kickback and Patient Referral laws should be revised to foster, rather than hinder, integrated relationships that help hospitals and physicians work together to better coordinate care for patients.

Background

As the health care field explores new payment and delivery system models that emphasize value over volume and the Triple Aim of improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care, hospitals are actively exploring clinical integration – a move away from working in silos toward emphasizing teamwork to coordinate care. Increasingly, public and private payers are holding hospitals accountable for reducing costs and improving quality in ways that can be accomplished only through teamwork with physicians and other health care professionals within and across sites of care, including the alignment of financial incentives. However, hospitals attempting to achieve the care coordination required by these new payment and delivery system models face significant legal barriers. Chief among these are outdated rules governing relationships between hospitals, physicians and other caregivers – portions of the Anti-kickback Statute and the Ethics in Patient Referral Act (also known as the "Stark law") and the Civil Monetary Penalty (CMP) law.

Congress recently acknowledged the need for change to the CMP law to remove impediments to improving care for patients and remedy the government's problematic interpretation of the law. The recently passed Medicare Access and CHIP Reauthorization Act of 2015 limits the scope of this prohibition, which had prohibited hospitals from offering physicians incentives to follow evidence-based care guidelines, so that a hospital or critical access hospital is only subject to CMPs for making payments to reduce or limit *medically necessary* care. The AHA advocated for this change and is pleased that the Congress has lifted this significant barrier to hospital "gainsharing" arrangements with physicians.

Key Priorities

The AHA recommends two additional, specific changes to enhance hospitals' ability to improve health and health care. They are:

- Creating an anti-kickback safe harbor for clinical integration programs; and
- Refocusing the Stark law on its original intent.

Creating an Anti-kickback Safe Harbor for Clinical Integration Programs
The Anti-kickback law's main purpose is to protect patients and federal health programs from fraud and abuse. The law states that anyone who knowingly and willfully receives or pays anything of value to influence the referral of federal health program business – including Medicare and Medicaid – can be held accountable for a felony. Today, the law has been stretched to cover any financial relationship between hospitals and doctors. For example, if a hospital rewards a physician for following evidence-based clinical protocols, the reward could be construed as violating the Anti-kickback law, since technically such a reward could

influence a physician's order for treatment or services. In acknowledgement that there are cases where the Anti-kickback statute thwarts good medical practices, Congress has periodically created "safe harbors" to protect those practices. Congress should create a safe harbor for clinical integration programs. The safe harbor should allow all types of hospitals to participate, establish core requirements to ensure the program's protection from anti-kickback charges, and allow flexibility in meeting those requirements so the programs can achieve their health goals.

Refocusing the Stark Law on its Original Intent

The Stark law was originally enacted to ban physicians from referring patients to facilities in which they have a financial interest (known as self-referral). However, a tight web of regulations and other prohibitions that have grown around the law can now prevent arrangements that encourage hospitals and physicians to work together to improve patient care. Specifically, the law prohibits hospitals from making payments to physicians that are tied to achievements in quality and efficiency – rather, payments must be for hours worked only. For example, if a hospital pays a physician to help patients manage their diabetes according to a well-designed medical protocol, both the hospital and physician risk being in violation of the Stark law. Congress should return the Stark law to its original focus of regulating self-referral to physician-owned entities by removing compensation arrangements from the definition of "financial relationships" subject to the law.

American Hospital Association®

Reforming Program Integrity Efforts to Improve Accuracy, Fairness and Transparency

AHA View

The Centers for Medicare & Medicaid Services (CMS) and Congress must undertake comprehensive reform of the audit processes to be more accurate, fair and transparent.

Background

Hospitals take seriously their obligation to bill properly for the services they provide to Medicare and Medicaid beneficiaries and are committed to working with CMS to ensure the accuracy of Medicare and Medicaid payments. However, hospitals are drowning in a deluge of unmanageable medical record requests and inappropriate payment denials made by redundant government auditors. This wastes hospitals' resources by diverting money from patient care and contributes to growing health care costs.

In recent years, the number of program integrity auditors that review hospital claims to identify improper payments has increased dramatically. These audit contractors include Medicare recovery audit contractors (RACs) and Medicare administrative contractors (MACs). RACs are charged with identifying improper Medicare fee-for-service payments – both overpayments and underpayments. They are paid on a contingency fee basis, receiving a percentage of the improper payments they identify and collect. MACs conduct pre-payment and post-payment audits and also serve as providers' primary point-of-contact for enrollment and training on Medicare coverage, billing and claims processing. Additional entities that may audit hospitals' Medicare claims for payment accuracy include Medicaid RACs, the Supplemental Medicare Review Contractor, the Comprehensive Error Rate Testing contractor, and the Department of Health and Human Services (HHS) Office of Inspector General (OIG).

Key Priorities

The AHA recommends the following actions to reform the audit process to be more accurate, fair and transparent:

- Providing audit relief through legislation;
- Fixing the overburdened appeals process;
- Ensuring payment for all medically necessary services; and
- Preventing improper payments.

Providing Audit Relief through Legislation

The AHA urges Congress to reform the RAC program by realigning the financial incentives that drive RACs to deny claims inappropriately. Specifically, Congress should:

- Change the RACs' current payment structure from a contingency fee that is paid on every claim to a fixed-price contract that does not incentivize them to deny claims;

- Assess RACs' financial penalties for poor performance;
- Eliminate CMS's application of the regulatory requirement that a claim must be filed within one year of the date the services were provided (the one-year filing limit) to rebilled outpatient (Part B) claims, which would allow hospitals to request outpatient payment for certain denied inpatient claims, no matter when the denial is made; and
- Limit RACs to considering only the medical information available when a patient was seen by his or her physician when determining whether an inpatient stay was necessary, or whether the care should have been provided in an outpatient setting.

In December 2014, CMS announced changes to the RAC program that will take effect upon commencement of new multi-year RAC contracts, which CMS is in the process of awarding. The future changes include providing more time for hospitals to contest appeals directly with RACs through a pre-appeal discussion period; requiring RACs to complete audits and provide results to hospitals within 30 days; reducing the number of records RACs can pull from hospitals with lower error rates (while potentially increasing the number from hospitals with higher error rates); and limiting the RAC lookback period to six months when reviewing the medical necessity of an inpatient admission. In addition, in April, the Medicare Payment Advisory Commission (MedPAC) put forth a package of recommendations designed to address its concerns about the RAC program, including tying a RAC's contingency fee to its denial overturn rate. While these are steps in the right direction, they fall far short of necessary fundamental RAC reform.

Fixing the Overburdened Appeals Process

The HHS Office of Medicare Hearings & Appeals (OMHA) in December 2013 announced that it had suspended assignment of appealed Medicare claim denials to an administrative law judge (ALJ) until it clears the significant backlog in its workload. Inappropriate RAC denials are a significant contributor to the dramatic increase in the ALJs' workload because their inaccurate denials leave hospitals with no other option but to appeal in order to receive payment for medically necessary services they delivered to Medicare beneficiaries. As a result, hospitals must wait an estimated two years before their appeals are heard by an ALJ, during which time the disputed funds are recouped by CMS. It is at an ALJ hearing – the third level of appeal – that hospitals have the first opportunity to receive an objective, independent review of denied claims and where they have experienced a high level of success in overturning denials. Specifically, the HHS OIG has shown that hospitals win an overturn of appealed Part A claim denials 72 percent of the time at the ALJ level. Appeals at the first two levels of appeal are heard by Medicare contractors that too often simply affirm the original decision to deny the claim. The significant delays in obtaining an ALJ hearing and decision mean that hospital resources that could be used for other priorities, such as patient care, are held captive for years.

In May 2014, the AHA and three hospitals filed suit in federal court to compel HHS to meet statutory deadlines for timely review of Medicare claims denials. In fall 2014, in an apparent attempt to alleviate the appeals backlog, CMS offered acute care and critical access hospitals the opportunity to settle certain denied Medicare claims for 68 percent of the claims' value. Whether that initiative will reduce the appeals backlog significantly is not yet clear, and the AHA's lawsuit is ongoing. In addition, the AHA continues to urge CMS to address the underlying cause of the appeals backlog by focusing on fundamental RAC reforms that would curb the significant volume of inappropriate denials. CMS could take additional steps immediately to mitigate the impact of the ALJ backlog on hospitals, including enforcing statutory timeframes within which appeals determinations must be made; permitting hospitals to wait to repay claims denied by RACs until after an ALJ hearing; and addressing other systemic issues within the RAC program that lead to avoidable claim denials and appeals.

Ensuring Payment for All Medically Necessary Services

Medical necessity is the top reason why RACs deny claims. However, roughly half of medical necessity denials are because the RAC claimed treatment should have been provided on an outpatient rather than inpatient basis, not because the RAC believes the care provided was unnecessary. Historically, in these cases, CMS denied the claim in full and permitted the hospital to rebill only for selected ancillary Part B services (e.g., diagnostic laboratory tests and X-rays), rather than for full Part B payment. After the AHA and five hospital organizations filed a lawsuit in federal court challenging that general nonpayment policy, CMS modified the policy through a March 2013 "Administrator's Ruling" and subsequently in the fiscal year (FY) 2013 inpatient prospective payment system (PPS) final rule. CMS specified that hospitals may rebill under Part B for denials of services provided on or after Oct. 1, 2013, but only if they meet the one-year filing limit.

Since RACs often review claims that are more than a year old and can review claims that are up to three years old, CMS's policy to allow rebilling only for services within the one-year filing limit is insufficient. The practical effect is that many denials are ineligible for rebilling at the time they are denied. This artificial barrier to payment violates CMS's statutory requirement to pay hospitals for all reasonable and necessary outpatient services provided to Medicare beneficiaries.

In the FY 2014 inpatient PPS rule, CMS also finalized its "two-midnight" policy whereby the agency will generally consider hospital admissions spanning two midnights as appropriate for payment under the inpatient PPS. In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. The policy took effect Oct. 1, 2013, but CMS and Congress have acted to delay enforcement of the policy a number of times. Most recently, the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2) extended the partial enforcement delay of the two-midnight policy through Sept. 30, 2015. MedPAC, as part of its recent work designed to improve the RAC

program, recommended that CMS withdraw the two-midnight rule. The AHA, several hospital associations and four hospital organizations have challenged the two-midnight criteria, along with a related physician order/certification requirement and the one-year filing limit for rebilled claims, in a lawsuit filed in April 2014. The suit is currently pending in federal court.

Preventing Improper Payments

CMS must take proactive steps to prevent improper payments and thereby alleviate the need for audits and denials in the first place. Doing so would reduce hospital burden and mitigate the current appeals backlog. The AHA continues to urge CMS to offer more substantive provider education to assist hospitals in proactively identifying the most common payment errors and the remedies needed to eliminate errors and related payment denials.

In addition, the AHA provides members with educational resources to help hospitals better understand the RAC and Medicare appeals processes. A series of Advisories and Audit Education webinars can be accessed through AHA's RAC policy portal under "Education and Tools" at *www.aha.org/rac*.

American Hospital Association®

Expanding Medical Liability Reform

AHA View

The AHA supports a more sensible medical liability system that relies upon evidence-based standards, reduces frivolous lawsuits and produces prompt and fair compensation for injured patients.

Background

The high costs associated with the current medical liability system not only harm hospitals and physicians, but also patients and communities. High premium costs and highly-publicized lawsuits can prompt hospitals and physicians to close services, undermining access to care. The Congressional Budget Office has found that medical liability reform could save between $17 billion and $62 billion over 10 years, depending on the polices implemented.

Key Priorities

The AHA recommends the following actions.

Enacting Sensible Medical Liability Reform

The AHA seeks reforms to the current medical liability system based on the following principles:

- Model federal proposals on proven state models of reform;
- Cap non-economic damages;
- Allow courts to limit lawyers' contingency fees;
- Make each party liable only for the amount of damages directly proportional to its responsibility;
- Enact a reasonable statute of limitations after the date of the manifestation or discovery of an injury; and
- Establish "safe harbor" protections for providers who follow evidence-based clinical practice guidelines.

In recent years, several bills have been introduced that would have helped curb escalating medical liability costs, including comprehensive legislation based on California's Medical Injury Compensation Reform Act, which capped non-economic damages and attorneys' fees, among other reforms. While we anticipate that, during 2015, legislative efforts may be focused on more limited, targeted solutions to reform the medical liability system, the AHA will continue to press for comprehensive reform.

Establishing an Administrative Compensation System (ACS)

The AHA supports an ACS in which decisions on compensation in medical liability cases are made by trained, impartial adjudicators outside of the regular tort system, based on whether the injury was avoidable. Specifically, an ACS would compensate patients for injuries that could have been avoided during medical care, based upon nationally developed, evidence-based clinical guidelines. The ACS would handle claims for injury during medical care through an administrative process administered by the states.

American Hospital Association®

Promoting Hospital Price Transparency

AHA View

Consumers and their families deserve meaningful information about the price of their hospital care, and America's hospitals are committed to providing it. But more can, and should, be done to share health care information with the public, including, but not limited to, hospital pricing information. The AHA and its members stand ready to work with consumer groups and payers on innovative ways to build on efforts already occurring at the state level, and share information that helps consumers make better choices about their health care.

Background

Over the past several years, there has been considerable attention paid to the issue of health care price transparency. While public focus on this issue is not new, trends in the health care marketplace are highlighting its importance. What consumers must pay for health care has long been an issue for the uninsured, but growing enrollment in plans with higher levels of deductibles and coinsurance is creating a greater demand for meaningful price information for insured patients as well. Employers have been moving in this direction for a number of years. Newly insured individuals under the Affordable Care Act are choosing "bronze" and "silver" plans that include significant levels of cost sharing.

Board Policy

The AHA Board of Trustees has adopted a policy calling for information to be presented in a way that:

- is easy to access, understand and use;
- creates common definitions and language describing hospital pricing information for consumers;
- explains how and why the price of patient care can vary;
- encourages patients to include price information as just one factor to consider when making decisions about hospitals and health plans; and
- directs patients to more information about financial assistance with their hospital care.

The AHA believes that the path to price transparency has four parts:

1) Expanding existing state transparency efforts so that state governments, working with their state hospital associations, make hospital price information available to consumers;
2) Increasing health plan transparency – health plans should serve as the go-to source for the insured, providing enrollees with information about out-of-pocket costs based on their benefit structure, using a uniform glossary of terms written in plain English;
3) Ensuring providers and insurers agree on consumer-friendly pricing language – common terms, definitions and explanations to help consumers better understand the information provided; and
4) Engaging in further research to determine what consumers find useful.

Key Priorities

Expanding State-based Efforts

The AHA supports state-based efforts regarding price transparency, including the Health Care Price Transparency Promotion Act, which would require states to have or establish laws requiring hospitals to disclose information on charges for certain inpatient and outpatient services, and require health insurers to provide to enrollees upon request a statement of estimated out-of-pocket costs for particular health care items and services. Introduced by Reps. Michael Burgess (R-Texas) and Gene Green (D-Texas), the legislation also would require the Agency for Healthcare Research and Quality to study the types of health care cost information that consumers find useful, and the ways it might best be distributed.

Multi-Stakeholder Process

In 2014 the AHA participated in a multi-stakeholder task force convened by the Healthcare Financial Management Association (HFMA) to address price transparency. The task force's report includes a set of principles as well as specific action steps required to achieve greater transparency. The report makes clear that achieving a more transparent system is a multi-stakeholder issue and will require consensus among hospitals, physicians and other care providers; the pharmaceutical and medical device industries; commercial and government payers; employers; patients and consumer advocates; and regulatory agencies to develop a workable, meaningful solution. In April 2014, the task force issued recommendations for health plans, health care providers and others, and a guide to help consumers estimate the cost of care. The AHA Board endorsed the principles and recommendations of the HFMA report.

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Maintaining Essential Resources

- Oppose Reductions to Payments for Hospital Outpatient Services
- Reject Proposals to Equalize Payments for Inpatient Rehabilitation Hospitals and Units and Skilled Nursing Facilities for Certain Services
- Reject Payment Reductions to Long-term Care Hospitals
- Reject Reductions to Payments for Graduate Medical Education
- Maintain Support for Small and/or Rural Hospitals
- Reject Reductions to Assistance to Low-income Medicare Beneficiaries (Bad Debt)
- Oppose Further Restrictions on Medicaid Provider Assessments
- Provide Resources to Support Emergency Preparedness and Response Capabilities
- Preserve Existing Restrictions on Physician Self-referral to Physician-owned Hospitals
- Reject Harmful Restrictions on the 340B Drug Pricing Program

American Hospital Association®

Oppose Reductions to Payments for Hospital Outpatient Services

AHA View

The AHA strongly opposes so-called "site-neutral" policy proposals that would reduce Medicare payment rates for services furnished in hospital outpatient departments (HOPDs) to a residual amount of the physician fee schedule (PFS) payment rate or to the rate paid in Ambulatory Surgery Centers (ASCs).

Background

Congress is considering several proposals, including three originally raised by the Medicare Payment Advisory Commission (MedPAC), which would cap total payment for certain HOPD services at the physician rate or at the rate paid in ASCs. One proposal, recommended by MedPAC in 2012, would cap payment for non-emergency department evaluation and management services (clinic visits) in HOPDs at the rate paid to physicians for providing the services in their private offices. Specifically, a hospital would be paid an amount calculated as the difference between the payment rate the physician would receive under the Medicare PFS for a service furnished in his or her private office and the PFS rate paid for the service furnished in an HOPD. MedPAC estimated that this policy would cut hospital outpatient payments by 2.8 percent, or $900 million per year. However, given changes made by Medicare in 2014 that collapsed the coding structure for hospital outpatient clinic visits, it is unclear how Congress could enact this ill-advised recommendation.

MedPAC subsequently expanded its site-neutral payment recommendations to include the services in 66 selected ambulatory payment classifications (APCs). These outpatient services are integral to hospitals' service mission. MedPAC estimates that this recommendation would cut hospital outpatient payments by 2.7 percent, or $1.44 billion, in one year. As an example of these steep cuts, a hospital's payment for a level II echocardiogram without contrast would drop from $427.27, the average amount paid in 2014 under the outpatient prospective payment system (OPPS), to $163.57 – a 62 percent reduction.

A third MedPAC proposal would base HOPD payment for an additional 12 APCs on the rates Medicare pays for these services in ASCs. This alternate proposal would reduce hospital outpatient payment by 1.7 percent, or $590 million per year.

In addition, President Obama's fiscal year (FY) 2016 budget proposal recommends lowering payment for services provided in off-campus HOPDs to either the physician or ASC rate, resulting in $29.5 billion in federal savings over 10 years.

Key Facts

Implementing site-neutral payment policies would further erode Medicare payments to HOPDs and threaten patient access to care.

- **Medicare Already Covers Less than the Cost of Care.** According to data presented at MedPAC's December 2014 meeting, hospitals' Medicare margins were negative 12.4 percent for outpatient services in 2013. Additional cuts to HOPD payments threaten beneficiary access.

- **Hospitals Care for Vulnerable Populations.** Site-neutral payment policies put critical hospital-based services at risk, such as care for low-income patients and underserved populations. Unlike physician offices and ASCs, hospitals play a unique and critical role in their communities by providing a wide range of acute-care and diagnostic services, supporting public health needs, and offering other services that promote the health and well-being of the community. For example, hospitals provided $46.4 billion of uncompensated care in 2013. By contrast, many physician offices and ASCs do not serve Medicaid or charity care patients. Relative to patients seen in physician offices, patients seen in HOPDs are:

  - 2.5 times more likely to be Medicaid, self-pay or charity patients;
  - 1.8 times more likely to be dually eligible for Medicare and Medicaid;
  - 1.8 times more likely to live in high-poverty areas;
  - 1.7 times more likely to live in low-income areas; and
  - 1.7 times more likely to be Black or Hispanic.

- **Hospitals Provide 24/7 Emergency Standby Services.** Site-neutral payment policies also undercut the ability of hospitals to continue to provide emergency standby services that Americans rely upon so heavily, such as: (1) around-the-clock access to health care services, including specialized resources; (2) safety-net services involving caring for all patients who seek emergency care, regardless of ability to pay; and (3) disaster readiness and response capabilities that ensure that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions. These critical services, while often taken for granted, represent essential components of our nation's health and public safety infrastructure.

  However, this role is not explicitly funded. There is no payment for a hospital and its staff to be at the ready until a patient with an emergency need arrives. Without such explicit funding, this role is built into the cost structure of full-service hospitals and supported by revenue from direct patient care – a situation that does not exist for physician offices, ASCs or any other type of provider. Hospitals today face challenges in maintaining this role, such as staffing and space constraints, greater expectations for preparedness, the erosion of financial support from government payers, and the loss of patients to other settings that do not have the added costs of fulfilling the standby role.

- **Hospitals Treat Sicker Patients.** Site-neutral payment cuts also would make it harder for HOPDs to continue to care for patients who are too complex for physician offices and ASCs. For example, physicians refer more complex patients to HOPDs for safety reasons, as hospitals are

better equipped to handle complications and emergencies. As such, compared to freestanding physician offices, HOPDs treat patients who are burdened with more severe chronic conditions and, in Medicare, have higher prior utilization of hospitals and emergency departments.

- **Hospitals Are Subject to a Higher Level of Oversight.** HOPDs must comply with a much more comprehensive scope of licensing, accreditation and regulatory requirements than do free-standing physician offices and ASCs, resulting in a higher cost structure than these other providers. These requirements are important and reflect the broad mission of hospitals to protect and care for their community, patients, staff and visitors at all times.

- **Hospital Payments Should Reflect HOPD Costs, Not Physician or ASC Payments.** HOPD payment rates are based on hospitals' audited cost reports and claims data. In contrast, the physician payment schedule (and specifically the practice expense component) is based on physician survey data and has been held flat for years due to the cost of various physician payment "fixes." ASC payment rates are based on HOPD rates because ASCs do not report their costs to Medicare.

The chart below outlines some of the key differences in regulatory requirements HOPDs face versus ASCs and physician offices.

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	✔	✔	✔

- **Applying Site-neutral Policies to Evolving OPPS Will Result in Unfair and Inaccurate Payments.** In making its recommendations, MedPAC did not consider the sweeping changes Medicare has undertaken in recent years in its HOPD payment policies. In particular, recent OPPS regulations include new policies that significantly increase the amount of packaging in all APCs. In general, as the Centers for Medicare & Medicaid Services carries out its intentions, year after year, to shift the OPPS more definitively away from a per-service fee schedule to a prospective payment system with larger payment bundles, the package of services paid under the OPPS will become less comparable to those paid under the PFS. As a result, the implementation of site-neutral payment policies is more likely to result in increasingly unfair and inaccurate hospital payments. Further, larger payment bundles provide incentives to improve efficiency and better manage resources – site-neutral payment policies will hamper this innovation.

The Medicare payment systems for physicians, ASCs and HOPDs are complex and fundamentally different, with many moving parts. Practically speaking, this makes the application of a site-neutral policy unstable. Any small technical or methodological change to one of the payments systems could result in a significant change to the other payment systems.

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Reject Proposals to Equalize Payments for Inpatient Rehabilitation Hospitals and Units and Skilled Nursing Facilities for Certain Services

AHA View

Some in Congress are discussing the possibility of equalizing the rates paid to inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs) for Medicare patients with selected conditions in order to reduce costs to the program. This misguided proposal would limit access to care for Medicare beneficiaries who have medical needs that can be met only in IRFs. Medicare cannot require IRFs to provide this hospital-level care but pay them SNF rates.

Background

IRFs provide unique clinical value for patients who require hospital-level care and intensive rehabilitation after an illness, injury or surgery. They have faced significant scrutiny from Congress and the Centers for Medicare & Medicaid Services (CMS) in recent years that has led to the application of strict criteria for the types of patients IRFs may treat, multiple payment cuts and other policy restrictions. Collectively, these policy changes have reshaped the population treated in IRFs by dramatically reducing the overall volume and steadily increasing the medical complexity of IRF patients.

The AHA has expressed serious concerns with a Medicare Payment Advisory Commission (MedPAC) proposal to reduce IRF payments to SNF levels for patients with selected conditions. The MedPAC approach lacks a structure to identify and differentiate the types of patients who need IRF rather than SNF care due to their clinical condition. To proceed with this approach would put at risk the Medicare beneficiaries who need IRF services.

IRFs provide a unique clinical setting for patients who need inpatient rehabilitation services. The chart below outlines the fundamental differences between IRFs' hospital-level care and SNF care:

IRFs vs. SNFs

Required by Medicare	IRFs	SNFs
Close medical supervision by a physician with specialized training	Yes	No
24-hour rehabilitation nursing	Yes	No
Multidisciplinary team approach	Yes	No
3 hours of intensive therapy; 5 days per week	Yes	No
Patients must require hospital-level care	Yes	No
Physician approval of preadmission screen and admission	Yes	No
Medical care and therapy provided by a physician-led multidisciplinary medical team including specialty trained registered nurses	Yes	No
Discharge rate to community	70%	33%
2013 Medicare fee-for-service spending	$6.8 billion	$26.6 billion

Data source: Medicare Payment Advisory Commission.

Reject Proposals to Equalize Payments for Inpatient Rehabilitation Hospitals and Units and Skilled Nursing Facilities for Certain Services

Key Facts

- **IRFs Fill a Distinct Role.** IRFs treat a highly targeted group of patients who need both hospital-level treatment and intensive therapy. Relatively few Medicare beneficiaries meet these stringent criteria. The hallmark of IRF care is the combination of hospital-level care provided by a physician-led medical team, plus three hours of rehabilitation per day – a clinical focus not provided in any other setting.

- **IRFs Provide Better Quality.** Not only do IRFs provide a distinct service, they produce strong outcomes. MedPAC reported that, in 2013 (the latest year for which data are available), IRFs had a far higher rate of discharging patients to the community than SNFs (IRFs: 70 percent; SNFs: 33 percent). IRFs also had a far better record on avoidable rehospitalizations. MedPAC reported that, in 2013, 2.5 percent of patients were readmitted during an IRF stay, while 11.1 percent of SNF patients were readmitted during their stay.

- **IRFs Serve a Targeted Population.** IRF patients must meet very detailed admission criteria, which are among the most specific criteria required by Medicare. Through a series of policy decisions that substantially tightened these criteria, Congress and CMS have significantly decreased the number of Medicare patients treated in IRFs, with 122,000 fewer IRF patients discharged in 2013 compared to their peak in 2004. IRF admissions are expected to decrease further in fall 2015 when CMS reduces the condition codes that can qualify under the "60% Rule."

- **The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 Will Bring Systemic Change to All Post-acute Settings, Including IRFs.** The IMPACT Act requires all post-acute settings, including IRFs, to conduct standardized patient assessments and report consistent quality and resource use measures. These data will inform future post-acute payment reform efforts over the next three years, beginning in 2016. The law also will yield a model for a post-acute payment system that pays for all post-acute services based on patient characteristics.

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Reject Payment Reductions to Long-term Care Hospitals

AHA View

Under congressional reforms that will take effect in October 2015, AHA estimates that half of current long-term care hospital (LTCH) patients will move from a traditional LTCH payment level to a new payment category equal to the inpatient prospective payment system (PPS) rate. Given the magnitude of this change, now is not the time for Congress to impose further reforms or make reductions to LTCH payments. Rather, now is the time for the LTCH field and policymakers to focus on implementing this complex congressional mandate.

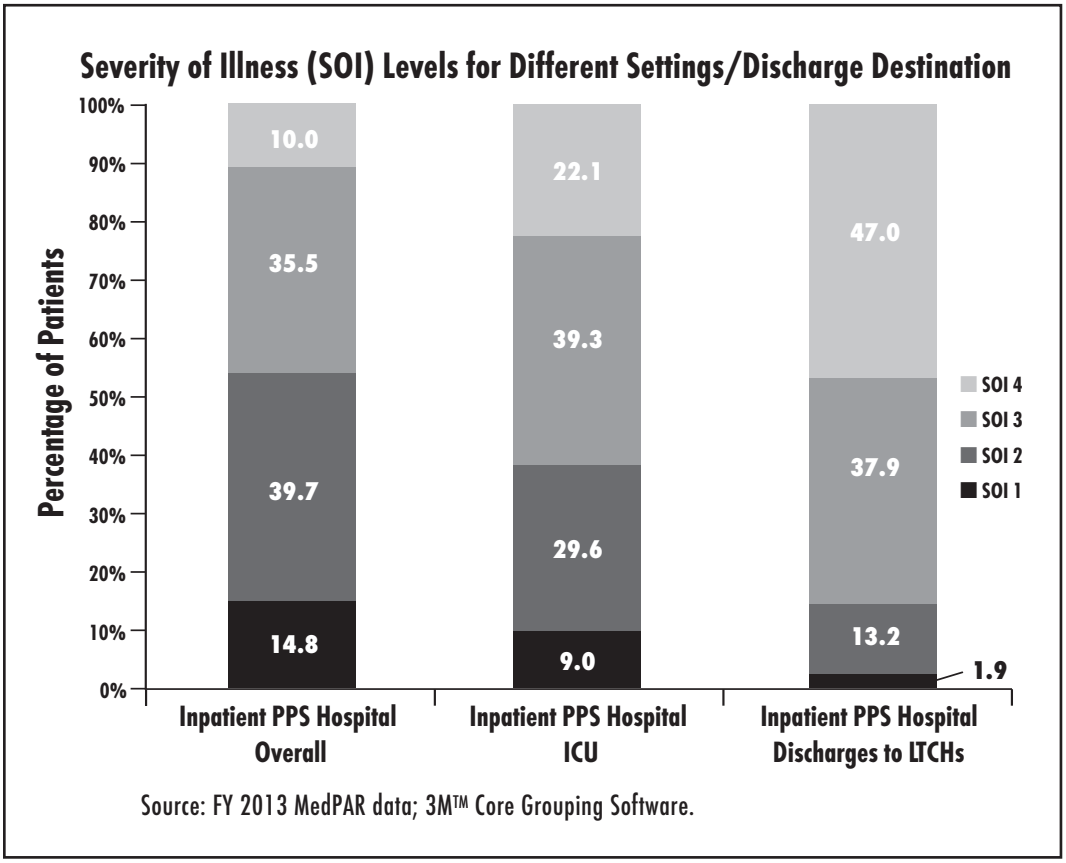
Background

LTCHs serve a critical role within the health care system, and the Medicare program in particular, by treating the sickest patients who need long hospital stays. In December 2013, Congress passed the Bipartisan Budget Act, which, among other changes, implements several reforms that will more clearly distinguish the LTCH role. These include a new, two-tiered payment system that will take effect in October 2015, under which LTCHs will be paid an LTCH-level rate for patients with higher severity of illness levels, and a lower rate, comparable to general acute care hospitals for patients with lower medical acuity.

The next step in implementing these reforms will be the release of a proposed rule on the LTCH PPS, which the Centers for Medicare & Medicaid Services issued April 17. The regulation contains the agency's proposal for new payment rates and its plan to add a site-neutral payment component to the LTCH PPS. The addition of site-neutral payment will be a major transformation for the LTCH field. Specifically, the AHA is studying the structure of the payment policy to identify any conditions that were grouped in the new PPS-equivalent category, which, due to high medical acuity, should not have been grouped in the traditional LTCH PPS category, and to identify other concerns. The new policy must not harm access to care for patients who need traditional LTCH services.

Key Facts

- **LTCH Patients are Severely Ill.** Data from general acute hospitals show that patients discharged to LTCHs have the highest medical severity when compared to patients in other settings. For example, as shown in the chart on the next page, 47 percent of inpatient PPS patients discharged to an LTCH have a severity of illness (SOI) level 4 (extreme severity) compared to only 22 percent of patients in inpatient hospital intensive care units (ICUs). Since LTCH patients are typically far sicker, their average length of stay is much longer: 26.8 days for LTCHs, 5.1 days for general acute hospitals, and 6.8 days for ICUs in general acute-care hospitals.



Source: FY 2013 MedPAR data; 3M™ Core Grouping Software.

- **LTCHs are Preparing their Organizations to Implement These Major Reforms.** LTCH clinical teams and staff are engaged in the significant planning and re-engineering of operations that is necessary to prepare for this evolution in the LTCH role. For example, they are adjusting the composition of their staff and re-tooling clinical pathways to fit the needs of a lower-acuity, short-stay patient population. Now is the time to allow them to focus on implementing these critical regulatory steps; it is not the time for additional cuts or reforms.

American Hospital Association®

Reject Reductions to Payments for Graduate Medical Education

AHA View

The AHA opposes proposals to reduce Medicare funding for graduate medical education (GME). The AHA supports legislation to create at least 15,000 new residency positions and end the 18-year freeze on the number of physician training positions that Medicare funds.

Background

Teaching hospitals fulfill critical social missions, including educating and training future medical professionals, conducting state-of-the-art research, caring for the nation's poor and uninsured, and standing ready to provide highly specialized clinical care to the most severely ill and injured patients. The Medicare program has long recognized its responsibility for funding its share of the direct and indirect costs of training medical professionals. Currently, Medicare makes two payments with an educational label: the direct graduate medical education (DGME) payment and the indirect medical education (IME) payment. In fiscal year (FY) 2012, Medicare paid an estimated $2.8 billion for DGME and $6.8 billion for IME.

- DGME Payments. DGME payments help fund the direct costs of operating residency programs, such as resident stipends and benefits, faculty salaries and benefits, and administrative overhead expenses such as classroom space. Medicare DGME payments are based on a hospital-specific, per-resident amount that was determined in 1984 and is updated annually for inflation. Medicare makes DGME payments to each hospital based on its Medicare share of total inpatient days. Teaching settings other than hospitals, such as community health centers, also can receive DGME payments. The total number of residents supported by Medicare is capped at 1996 levels.
- IME Payments. IME payments are explicitly made to compensate for the higher patient care costs associated with teaching hospitals, such as treating complex, severely ill patients, residents' "learning by doing" and greater use of emerging technology. Teaching hospitals offer specialized services such as trauma centers and burn units that can contribute to higher patient care costs. The IME payment adjustment is a percentage add-on to a hospital's inpatient prospective payment system payment, and varies based on the intensity of a hospital's teaching programs, as measured by the ratio of residents to hospital beds. The number of residents included in the calculation of the resident-to-bed ratio also is capped at 1996 levels.

Key Priorities

Reject Reductions to Medicare Funding

Some policymakers are advocating for significant reduction in Medicare GME payments to teaching hospitals. For example, the president's FY 2016 budget calls for reducing the IME adjustment by 10 percent, which would cut Medicare medical education payments by approximately $16.3 billion over 10 years and using a portion of the savings to fund the Targeted Support for GME program. The president would use $5.3 billion over 10 years to promote "the goals of higher value health care that reduces long-term costs." The program would

distribute competitive grants to teaching hospitals, children's hospitals and community-based consortia and other health care entities to support training in primary and preventive care.

Other proposals to change GME have focused on altering Medicare's GME financing structure and have either proposed reducing IME payments to hospitals or redistributing them, sometimes to non-hospital entities. A 2010 report from the Medicare Payment Advisory Commission (MedPAC) asserted that IME payments exceed costs and recommended using the "excess" amount for a performance-based payment program that would reward hospitals that meet unspecified educational outcomes and standards. The Commission also recommended that the Department of Health and Human Services study a range of issues, including the optimal number of residency slots needed by specialty. MedPAC did not recommend an increase in the number of residency positions.

In July 2014, an Institute of Medicine (IOM) committee also recommended sweeping changes to Medicare's GME financing structure. The IOM committee recommended phasing out the distinction between DGME and IME in favor of a single GME payment based on a per-resident amount, adjusted geographically. If implemented, the IOM proposal would end the current stable financing mechanism, uncouple Medicare GME payments from Medicare volumes, permit funds designated for teaching hospitals to be paid to other entities that do not treat Medicare patients and create additional government bureaucracies. According to the IOM committee's own projections, in year five of a 10-year phase out of Medicare GME funding, teaching hospitals would experience effectively a 35 percent cut in payment for GME. In addition, the IOM recommended reevaluating and reassessing the need for continued Medicare funding of GME after 10 years.

The AHA opposes proposals to alter the GME financing structure in a way that reduces DGME or IME payments to teaching hospitals. Reductions in Medicare funding for GME would threaten the stable and predictable financing teaching hospitals need to train physicians for evolving health care system needs and would limit the ability of teaching hospitals to offer state-of-the-art clinical and educational experiences.

Increase the Number of Physician Training Positions

The current cap on residency slots was set in the Balanced Budget Act of 1997 and restricts the number of residency slots for which hospitals may receive Medicare DGME funding. A cap also limits the number of residents that hospitals may count in their ratios of residents-to-beds, which affects IME payments.

These limits on the number of Medicare-funded residency training slots constrain the ability of hospitals to train new physicians. This is especially troubling when our nation is facing a critical shortage of physicians. Experts indicate that the nation could face a shortage of as many as 130,000 doctors by 2025. The expansion

of health care coverage is increasing overall demand for physicians and, therefore, is increasing the projected physician shortfall. Recent estimates by the Health Resources and Services Administration show the U.S. will need from 6,400 to 20,200 additional primary care physicians by 2020[i]. The Association of American Medical Colleges predicts a deficit of 45,400 primary care physicians because of coverage expansion by FY 2025[ii]. Physician shortages would hamper national efforts to improve access to care and may result in longer wait times for patients.

Some in Congress support ways to ease the cap on the number of training positions that Medicare will pay for. The AHA supports legislation to create at least 15,000 new residency positions and end the 18-year freeze on the number of physician training positions that Medicare funds.

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[i] Health Resources and Services Administration. (November 2013). Projecting the Supply and Demand for Primary Care Practitioners Through 2020. *http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf.*

[ii] Association of American Medical Colleges. (March 2015). The Complexities of Physician Supply and Demand: Projections from 2013 to 2025, Final Report. *https://www.aamc.org/downlod/426242/data/ihsreportdownload.pdf.*

American Hospital Association®

Maintain Support for Small and/or Rural Hospitals

AHA View

Medicare and other federal programs must account for the special circumstances of rural communities. The AHA focuses on protecting vital funding, securing the future of existing special rural payment programs – including the critical access hospital (CAH), sole community hospital (SCH), Medicare-dependent hospital (MDH) and rural referral center (RRC) programs – and relieving regulatory burden. With congressional budget crises a continued threat in Washington, the continued viability of small and rural health care providers remains in jeopardy.

Background

Approximately 51 million Americans live in rural areas and depend upon the hospitals in their communities. Remote geographic location, small size, limited workforce, physician shortages and often constrained financial resources pose a unique set of challenges for rural hospitals. Rural hospitals' patient mix also makes them more reliant on public programs and, thus, particularly vulnerable to Medicare and Medicaid payment cuts.

Key Priorities

Protecting Vital Funding

The AHA continues to advocate for policies that provide vital funding for rural and small hospitals. This includes:

- Ensuring CAHs continue to be paid at least 101 percent of costs by Medicare, and are paid at least the same by Medicare Advantage plans;
- Ensuring the current CAH mileage criteria do not change;
- Extending the Rural Community Hospital Demonstration program;
- Ensuring rural hospitals and CAHs have adequate reimbursement for certified registered nurse anesthetist services, including stand-by services;
- Providing CAHs with bed size flexibility;
- Removing unreasonable restrictions on CAHs' ability to rebuild;
- Allowing hospitals to claim the full cost of provider taxes as allowable costs; and
- Extending the 340B Drug Pricing Program to additional hospitals, and allowing the purchase of 340B drugs used during inpatient hospital stays for all eligible hospitals.

Securing the Future of Existing Special Rural Payment Programs

The Medicare Access and CHIP Reauthorization Act of 2015 contained several provisions important to rural hospitals and their patients, including multi-year extensions for:

- The enhanced low-volume hospital payment adjustment, which provides additional payments to hospitals with low patient volumes (through Sept. 30, 2017);

- The MDH program, which provides certain small and rural hospitals with additional payments to ensure greater financial stability (through Sept. 30, 2017);
- Ambulance add-on payments that fairly reimburse rural ambulance providers for their higher per-trip costs due to small patient volumes and long distances (through Dec. 31, 2017); and
- The outpatient therapy caps exception process (through Dec. 31, 2017) – although we oppose the cap's current application to services provided in the outpatient departments of hospitals and CAHs.

The AHA strongly advocated for extensions of these programs, and we will continue to urge Congress to renew these programs for the full fiscal year (FY) 2018 and beyond.

Relieving Regulatory Burden
Medicare policy changes and payment adjustments often have significant and problematic consequences for rural providers. The Centers for Medicare & Medicaid Services (CMS) should better account for the unique circumstances of rural providers in the rulemaking process, especially regarding the following policies:

Direct Supervision. CMS recently removed its moratorium on Medicare contractors enforcing its policies related to its "direct supervision" requirement of outpatient therapeutic services furnished in CAHs and small rural hospitals with 100 or fewer beds. For 2015 and beyond, the agency requires a minimum of direct supervision for all outpatient therapeutic services furnished in hospitals and CAHs, unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic service. The AHA is deeply disappointed that CMS did not heed the concerns voiced by CAHs and small rural hospitals that this policy will be difficult to implement, will reduce access and is clinically unnecessary. The AHA supports the Protecting Access to Rural Therapy Services Act (H.R. 1611/S. 257), which would:

- Adopt a default standard of "general supervision" for outpatient therapeutic services, supplemented with a reasonable exceptions process with provider input to identify those specific procedures that require direct supervision;
- Ensure that, for CAHs, the definition of "direct supervision" is consistent with the CAH conditions of participation that allow a physician or non-physician practitioner to present within 30 minutes of being called; and
- Prohibit enforcement of CMS's retroactive reinterpretation that the "direct supervision" requirements applied to services furnished since Jan. 1, 2001.

96-hour Rule. CMS has published guidance, in relation to its two-midnight admissions policy, that implies that the agency will begin enforcing a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. While CAHs must maintain an annual *average* length of stay of 96 hours, they offer some critical medical services that have standard lengths of stay greater than 96 hours. Enforcing the condition of payment will force CAHs to eliminate these "96-hour plus" services. The resulting financial pressure will severely affect their ability to operate and, therefore, threaten access to care for beneficiaries in rural communities. The AHA supports the Critical Access Hospital Relief Act (H.R. 169/S. 258), which would remove the 96-hour condition of payment. CAHs would still be required to satisfy the condition of participation requiring a 96-hour annual *average* length of stay.

Electronic Health Records (EHRs) and Meaningful Use. The AHA continues to be concerned about the impact of the EHR incentive program on small and rural providers. Specifically, this program should close, not widen, the existing digital divide. Yet, CMS data indicate that CAHs, in particular, have found it more challenging to meet meaningful use requirements than their urban counterparts, partly due to limited vendor choice and capacity.

Maintaining Access to Capital Funding

Small and rural hospitals are often at a natural disadvantage for borrowing money. They generally have a limited service area, slower population growth, fewer assets, physician recruiting and retention challenges and lower real or potential credit ratings. Generally, smaller hospitals must have substantially stronger financial ratios to receive the same credit rating as a larger hospital.

The AHA supports the Municipal Bond Market Support Act of 2015 (H.R. 2229), which would permanently increase the bank qualified annual debt limit from $10 million to $30 million, index that amount for inflation and apply it to individual borrowers. The $10 million limit was created in The Tax Reform Act of 1986 and is worth significantly less today due to inflation. Bank qualified debt allows hospital bond authorities to directly place hospital bonds with banks, particularly community banks, enabling them to deduct a percentage of the carrying costs for purchasing these bonds as with their other investments. As a result, hospitals pay up to 0.5 percentage points less in borrowing costs for their debt. These changes would ease rural hospital access to the capital markets and lower the cost of financing needed infrastructure.

Small and rural hospitals often cannot access the capital necessary to make critical renovations and upgrades because they do not meet the high benchmarks bond rating agencies require to earn investment-grade ratings. The AHA continues to work to ensure adequate funding and efficient operation of federal hospital

financing programs such as the Department of Agriculture's Community Facilities Direct Loan and Grant, and Community Facilities Loan Guarantee programs, and the HUD 242 Hospital Mortgage Insurance program. The Community Facilities programs primarily finance health care, public safety and educational facilities. The department anticipates servicing 8 million mrural residents through the financing of these types of new and improved community facilities or 14 percent of the rural population in 2015. While the HUD 242 Mortgage Insurance Program has approved several refinancings recently, since 2012 it has been slow to approve new entrants into the program. With the rating agencies maintaining a negative outlook for nonprofit hospitals, HUD leadership is more fully supporting the mission of the Section 242 program so that HUD is beginning to re-emerge to play a role in hospital financing. The AHA continues to work with HUD 242 leadership to find ways to re-energize the 242 program so that it can increase its presence in hospital capital financing.

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Reject Reductions to Assistance to Low-income Medicare Beneficiaries (Bad Debt)

AHA View

The Medicare program must continue to reimburse hospitals for the unpaid debt they incur when low-income Medicare beneficiaries cannot make their coinsurance and deductible payments. Congress should reject further cuts to hospital payments for assistance in covering these financial obligations.

Background

The Medicare program requires its beneficiaries to pay a portion of the cost of their care, for example, through deductibles and coinsurance. Many low-income beneficiaries cannot pay these amounts to the hospital, resulting in unpaid debt (sometimes referred to as "bad debt"). Historically, Medicare reimbursed hospitals for 100 percent of the debt incurred by Medicare beneficiaries, particularly those with low incomes. However, the Balanced Budget Act of 1997 reduced that 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 reimbursement to 70 percent when the negative effects of cutting payments for the most vulnerable and poor Medicare beneficiaries became evident. The Middle Class Tax Relief and Job Creation Act of 2012 again reduced these payments – for prospective payment system (PPS) hospitals from 70 percent to 65 percent beginning in fiscal year (FY) 2013, and for critical access hospitals (CAHs) from 100 percent to 65 percent, phased-in over three years beginning in FY 2013. Thus, for CAHs, Medicare will pay 65 percent of allowable bad debt in 2015 and beyond.

The Centers for Medicare & Medicaid Services (CMS) has set forth stringent criteria that must be met in order for unpaid Medicare deductibles and coinsurance to be reimbursed. For example, CMS requires hospitals to ensure that reasonable collection efforts were made and the debt was actually uncollectible.

Key Facts

- **Out-of-Pocket Expenses Can Be Significant.** Beneficiaries' out-of-pocket expenses for Medicare can be significant and, unlike much private insurance, there is no maximum amount. In 2015, the Part A hospital deductible is $1,260 per benefit period. The Part B deductible is $147 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 $105 per month, which is "means tested" depending on the beneficiary's income. Although this premium cannot become 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. This is especially true given that about half of Medicare beneficiaries have incomes between 100 and 300 percent of the federal poverty level (FPL), or $11,770 to $35,310 for an individual. Below is an example of the cost sharing that would be incurred by a Medicare beneficiary with one hospital stay and associated physician visits in 2015 (in addition to this cost sharing, the beneficiary will have paid approximately $1,260 in Part B premiums for the year).

Service	Medicare-approved Payment	Beneficiary Cost-sharing
Inpatient Hospital Stay	$16,000	$1,260
Physician	$10,000	$2,147
Total	**$26,000**	**$3,407 + $1,260 in Part B premium = $4,667**

- **Dually Eligible Beneficiaries Account for Large Portion of Bad Debt.** In addition, about 20 percent of Medicare beneficiaries are dually eligible – low-income seniors and younger persons with disabilities who are enrolled in both Medicare and Medicaid. To qualify, a beneficiary's income is generally limited to less than the FPL – $11,770 for a single person in FY 2015. These Medicare beneficiaries receive coverage under Medicaid, as well as Medicaid's assistance in paying Medicare premiums and cost sharing. Cost sharing varies by state; however, Medicaid typically pays much less than the full deductible and co-insurance due. The unpaid amount is classified as Medicare bad debt. Although these dually eligible beneficiaries account for roughly 20 percent of Medicare beneficiaries, they account for about 59 percent of hospitals' Medicare bad debt.

  Finally, beneficiaries with incomes above the dual-eligible qualification level but below 120 percent of the FPL also may qualify for Medicaid assistance in paying Medicare premiums and cost sharing. For these beneficiaries as well, Medicaid typically pays much less than the full deductible and coinsurance due to hospitals, and the unpaid amount is classified as bad debt.

- **Disproportionate Effect on Safety-net and Rural Hospitals.** Reducing or eliminating reimbursement for unpaid debts disproportionately affects hospitals that treat high numbers of low-income Medicare beneficiaries – safety-net hospitals and rural hospitals:

  - Inner-city urban communities have large numbers and high proportions of Medicaid recipients and uninsured residents, and are highly likely to have large numbers and high proportions of low-income Medicare beneficiaries.
  - Hospitals in the highest quartile of disproportionate share hospital (DSH) patient percentages have Medicare bad debt reimbursement as a percentage of their Medicare revenue that is more than two times higher than hospitals in the lowest quartile of DSH patient percentages, on average.
  - Rural hospitals' small size leaves them with more limited cash flow and less of an ability to absorb payment cuts, which puts them and the patients they serve at risk. This is especially true given that rural hospitals have Medicare bad debt levels that are 50 percent higher than urban hospitals, on average.

- **The Medicare Program Already Pays Less than the Cost of Care.** The Medicare program already pays less than the cost of providing care to Medicare beneficiaries – only 88 cents on the dollar. Further reductions to hospital reimbursements for assistance covering the debts of low-income Medicare beneficiaries are inappropriate and exacerbate government underfunding, especially for those hospitals that serve many low-income beneficiaries.

American Hospital Association®

Oppose Further Restrictions on Medicaid Provider Assessments

AHA View

The AHA urges Congress to reject options that restrict states' ability to fund their Medicaid programs, in part, using provider assessments. The Medicaid provider assessment program has allowed state governments to expand coverage, fill budget gaps and maintain patient access to health services to avoid additional provider payment cuts by helping states finance their portion of the joint federal/state program. But some policymakers have called for restricting states' ability to use assessments as a financing tool.

Provider assessment cuts are just another name for Medicaid cuts that harm the millions of children, poor and disabled Americans who rely upon this vital program. Hospitals already experience payment shortfalls when treating Medicaid patients. Medicaid, on average, covers only 90 cents of every dollar spent treating Medicaid patients. Further cuts to hospital funding would put enormous pressure on already stretched state budgets and could jeopardize this critical health care safety-net program.

Background

The president's fiscal year (FY) 2013 budget proposed to phase down, but not eliminate, Medicaid provider assessments beginning in 2015. The administration estimated this would save $21.8 billion over 10 years. The House-approved FY 2013 budget reconciliation package contained cuts to Medicaid provider assessments of $11.2 billion over 10 years. The administration dropped provider assessment cuts in subsequent budgets.

The Medicaid provider assessment program is a critical component to funding Medicaid programs across the country. Over its 46-year history, Medicaid has become the nation's health care safety net, serving as a buffer to the perils of an uncertain economy by providing access to health services for those who cannot afford private insurance. Nearly all states employ some form of provider assessments – on hospitals, intermediate care facilities, nursing homes, managed care organizations or pharmaceutical companies – as a means to fund their Medicaid programs and fulfill their providers' missions to care for the neediest of our society.

Following a congressional request, the Government Accountability Office in July 2014 released a report on states' use of various sources of funds to finance the non-federal share of Medicaid, such as provider assessments. This report found an increased state reliance on providers and local governments and the need for more transparency around state financing methods and payments to providers. In addition, the Centers for Medicare & Medicaid Services issued guidance on permissible health-related taxes in response to a May 2014 Department of Health and Human Services Office of Inspector General report on the taxing of Medicaid managed care plans.

Key Facts

- **Nearly 69 million low-income Americans rely on the Medicaid program to provide access to health care.** That includes:

- 1 in 3 children;
- 1 in 3 births;
- 8 million people with disabilities;
- More than 9 million low-income Medicare beneficiaries; and
- 1 in 4 poor non-elderly adults.

- **Medicaid also is the major payer for long-term care services for low- and middle-income elderly.** Medicaid pays for seven out of 10 people living in nursing homes. More than a quarter of all mental health funding is from Medicaid. And according to the Kaiser Family Foundation, during the recession from 2007 to 2009, 6 million people were covered by Medicaid who would have otherwise gone without health care coverage.
- **With implementation of the Affordable Care Act, as many as 11 million more people may be enrolled in Medicaid beginning in 2015** (based on January 2015 Congressional Budget Office estimates).
- **Any reduction or elimination of Medicaid provider assessments would be on top of Medicaid cuts made at the state level.**

American Hospital Association®

Provide Resources to Support Emergency Preparedness and Response Capabilities

AHA View

The AHA supports increasing the fiscal year (FY) 2016 appropriation for the Hospital Preparedness Program (HPP) and making changes in its distribution of funding in order to help hospitals and health systems to sustain, develop and update their emergency preparedness and response capabilities. Hospital emergency preparedness requires a significant investment in staff and resources. It is not a one-time investment; rather, it is a dynamic process that changes over time. Hospitals and health systems learn from each disaster and emergency situation, such as the recent Ebola crisis, and it is crucial that they have the appropriate funding to adopt best practices and train staff, incorporate new technology into their emergency readiness plans and have the ability to care for their communities when a disaster, disease outbreak or terrorist attack occurs. However, annual appropriations for the HPP, the primary federal funding program for hospital emergency preparedness, have not kept pace with the ever-changing and growing threats faced by hospitals, health care systems and their communities.

Background

Hospitals, as a key component of the nation's critical infrastructure, play an essential role in emergency preparedness and response. Specifically, as part of their emergency standby role, hospitals play an essential role in disaster response, whether they are rural hospitals or Level 1 trauma centers. In the past several years, hospitals in Georgia, Nebraska, New York, Massachusetts, Oklahoma, Texas and many other locations have responded to devastating emergencies by activating their emergency plans to save lives and care for the seriously ill and injured.

Since 2002, the HPP has provided critical funding and other resources to aid hospitals' response to a wide range of emergencies. The HPP has supported greatly enhanced planning and response; facilitated the integration of public and private sector emergency planning to increase the preparedness, response and surge capacity of hospitals; and improved state and local infrastructures that help hospitals and health systems prepare for public health emergencies. These investments have contributed to saving lives during many events, such as the Joplin tornado, Superstorm Sandy, the Boston Marathon bombing and the Ebola crisis.

However, authorized funding levels and annual appropriations for the HPP have significantly declined since the program began. Congressionally authorized funding and appropriations for the HPP were $515 million per year in the early years of the program. However, the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA) reduced authorized funding for the HPP to $374.7 million per year for FYs 2014 through 2018. Further, for FY 2015, Congress appropriated only $255 million for the HPP – a more than 50 percent reduction from prior years. Similarly, the president's FY 2016 budget request recommends maintaining a funding level of $255 million for the HPP.

Key Priorities

Ensure Congressionally Mandated Funding for Ebola is Distributed to Hospitals

While working with members of Congress during the appropriations process that led to the emergency supplemental funding for Ebola, it was made clear that

Congress intended to reimburse hospitals for the costs they incurred in preparing for patients with confirmed or suspected Ebola. However, the Assistant Secretary for Preparedness and Response's (ASPR) Feb. 20 Funding Opportunity Announcement (FOA) for the HPP Ebola Preparedness and Response Activities releases only $194.5 million of the $576 million that Congress provided to the agency for Ebola preparedness, leaving $381.5 million in unallocated funds – meaning a total of 66 percent of funds are being withheld. Even taking into consideration the other initiatives that ASPR has identified for the use of the remaining $381.5 million, such as a national training and education center, domestic transportation and an injury compensation fund, ASPR could easily increase its allocations and adequately reimburse hospitals for their significant Ebola preparedness expenses.

The AHA strongly urges ASPR to develop a plan to release a portion of the remaining $381.5 million in order to ensure that Ebola Treatment Centers and state-designated Ebola hospitals are reimbursed for their related expenses on a cost basis. ASPR's FOA sets a maximum amount of $1 million for any Ebola Treatment Center. However, many Ebola Treatment Centers have spent well above $1 million on their preparedness activities and it is disappointing that ASPR will not recognize their extraordinary efforts and the associated costs of their preparations. The AHA urges ASPR to remove this cap and allow awardees to reimburse hospitals for their total costs related to Ebola readiness.

In addition, numerous state-designated hospitals were not included on the Centers for Disease Control and Prevention's (CDC) official list of Ebola Treatment Centers, even though they stepped up to prepare to care for Ebola patients, including undertaking all the same steps and activities as CDC's Ebola Treatment Centers, and incurred significant associated costs. These hospitals were designated or otherwise recognized by their states as hospitals that were prepared to treat Ebola patients. Some of these hospitals were assessed by the CDC's Rapid Ebola Preparedness teams, and some were not. Unfortunately, because these state-designated hospitals were not included on the CDC's official list, their incurred expenses are not recognized in ASPR's FOA in the same manner as hospitals that are on CDC's list. Also, Ebola Assessment Hospitals are not protected in ASPR's FOA, leaving any incurred costs associated with Ebola preparedness to be reimbursed at the complete discretion of the state or city. It is categorically unfair to disregard the costs incurred by these facilities when ASPR has $381.5 million available for just this purpose, and these hospitals were designated or recognized by their states.

Protecting Vital Funding for Hospital Preparedness

To help hospitals and health systems develop, update and sustain their emergency preparedness and response capabilities, the AHA urges the Obama administration and Congress to increase the FY 2016 appropriation for the HPP to $374.7 million, consistent with the amount authorized in PAHPRA. Erosion of this financial

support for disaster preparedness at a time when the need for these services is growing is inappropriate. In addition, the HPP funding cuts undermine the Department of Health and Human Services' ambitious emergency preparedness agenda to advance all-hazards preparedness and national health security by improving surge capacity and enhancing community and hospital preparedness for public health emergencies. This agenda will be difficult to achieve if HPP funding is not improved.

The AHA further recommends that Congress ensure that the majority of the HPP funding is awarded to hospitals and health systems in order to enhance their preparedness and surge capacity. In recent years, hospitals have received only a fraction of the HPP funds. The states, territories and directly funded cities that are allocated HPP funds keep a significant percentage of the total amount they receive for their own indirect costs. Of the remaining amount, little, if any, has been awarded to the hospitals and health systems that provide care to victims of public health emergencies and other disasters; rather, the majority is currently directed to regional health care coalitions and other types of providers.

American Hospital Association®

Preserve Existing Restrictions on Physician Self-referral to Physician-owned Hospitals

AHA View

The AHA urges Congress to maintain current law preserving the ban on physician self-referrals to new physician-owned hospitals, and retaining restrictions on the growth of existing physician-owned hospitals. The AHA opposes any attempt to expand the number of physician-owned hospitals and supports tight restrictions on the growth of existing facilities.

Background

For decades, the Ethics in Patient Referrals Act ("Stark law") has shielded the Medicare program from the inherent conflict of interest created when physicians self-refer their patients to facilities and services in which they have a financial stake. But the Stark law's "whole hospital" exception permitted physicians to refer patients to those hospitals where they had an ownership interest in the entire facility rather than just in a subdivision, such as imaging or surgery. In 2010, the Affordable Care Act (ACA) limited the use of the "whole hospital" exception to existing physician-owned hospitals that had a Medicare provider number as of Dec. 31, 2010.

The ACA allows limited exceptions to the growth restrictions when "grandfathered" hospitals can demonstrate that their communities need additional capacity. For example, if a physician-owned hospital can show that it has the average or a higher number of Medicaid inpatient admissions and is located in an area with significant population growth and high bed occupancy rates, it may apply to increase its number of beds.

Some in Congress propose to weaken significantly Medicare's prohibition on physician self-referral to new physician-owned hospitals and loosen restrictions on the growth of grandfathered hospitals. The so-called Patient Access to Higher Quality Care Act (H.R. 976) would allow many more physician-owned hospitals to open and permit unfettered growth in all grandfathered hospitals. Closing the "whole hospital" exception loophole to the Stark law reduced the federal deficit by $500 million over 10 years, according to the Congressional Budget Office (CBO). The ill-advised Patient Access to Higher Quality Care Act would erase those savings and raise the deficit at a time when our nation is trying to control increases in health care costs.

Key Facts

The AHA opposes any changes to the restrictions in current law because:

- **Physician-owned hospitals provide limited or no emergency services, relying instead on publicly funded 911 services when their patients need emergency care.** The Department of Health and Human Services' Office of Inspector General reported that "[t]wo-thirds of physician-owned specialty hospitals use 911 as part of their emergency response procedures," and "[m]ost notably, 34 percent of [specialty] hospitals use 911 to obtain medical assistance to stabilize patients, a practice that may violate Medicare requirements."
- **Physician self-referral leads to greater utilization of services and higher costs**. CBO, the Medicare Payment Advisory Commission (MedPAC) and

independent researchers have concluded that physician self-referral leads to greater per capita utilization of services and higher costs for the Medicare program.

- **Physician-owned hospitals tend to cherry-pick the most profitable patients, jeopardizing communities' access to full-service care.** The Government Accountability Office (GAO), the Centers for Medicare & Medicaid Services and MedPAC all found that physician-owned hospitals' patients tend to be healthier than patients with the same diagnoses at general hospitals. Further, MedPAC and GAO found that physician-owned hospitals treat fewer Medicaid patients. This trend creates a destabilizing environment that leaves sicker and less-affluent patients to community hospitals, threatening the health care safety net.

American Hospital Association®

Reject Harmful Restrictions on the 340B Drug Pricing Program

AHA View

The 340B Drug Pricing Program is essential to helping safety-net providers stretch limited resources to better serve their patients and communities. The AHA strongly opposes any efforts to scale back or significantly reduce the benefits of the 340B program. In addition, the AHA supports program integrity efforts to ensure this vital program remains available to safety-net providers; expanding the program to certain rural hospitals; and eliminating the orphan drug exclusion for certain 340B hospitals.

Background

For more than 20 years, the 340B program has provided financial help to safety-net hospitals to manage rising prescription drug costs. Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations that care for many uninsured and low-income patients. These organizations include community health centers, children's hospitals, hemophilia treatment centers, critical access hospitals (CAHs), sole community hospitals, rural referral centers, and public and nonprofit disproportionate share hospitals that serve low-income and indigent populations.

The program allows 340B hospitals to stretch limited federal resources to reduce the price of outpatient pharmaceuticals for patients and expand health services to patients and the communities they serve. According to the Health Resources and Services Administration (HRSA), the federal agency responsible for administering the 340B program, enrolled hospitals and other covered entities can achieve average savings of 25 to 50 percent in pharmaceutical purchases.

HRSA is expected to issue by summer 2015 comprehensive interpretive guidance that will examine several areas pertinent to the 340B program, such as the definition of patient eligibility, contract pharmacy arrangements, and mechanisms to prevent both ineligible patients from receiving the benefit and duplicate discounts for Medicaid patients. Despite more oversight from HRSA and the program's proven record of decreasing government spending and expanding patient access to care, some want to scale it back or significantly reduce the benefits eligible hospitals and their patients receive from the program.

Key Priorities

Reject Efforts to Scale Back 340B

The AHA urges Congress and policymakers to reject any changes to the 340B program that would hurt patients and communities. Many 340B hospitals are the safety-net for their communities, and the program generates valuable savings for eligible hospitals to reinvest in programs that enhance patient services and access to care. While many hospitals use the 340B savings to provide free or reduced priced prescription drugs to vulnerable patient populations, the savings also allow hospitals to provide more patient services and programs. For example, hospitals use the 340B savings to provide free care for uninsured patients, as well as offer free vaccinations, services in mental health clinics, medication management programs and community health programs.

Some stakeholders, financed by the pharmaceutical industry, continue to spread misinformation about the program. However, the 340B program accounts for only 2 percent – or $6.5 billion – of the $325 billion in annual drug purchases made in the U.S. In addition, in 2013, one out of every three 340B hospitals had a negative operating margin. Meanwhile, pharmaceutical companies averaged an 18 percent[1] operating margin in 2013, and the price of pharmaceuticals continues to rise. Prescription drug prices rose 6.4 percent in the period from December 2013 to December 2014, up from 4.6 percent in the 12-month period from November 2013 to November 2014. This is an increase in the growth rate not seen since 1992. Scaling back the 340B program would hurt vulnerable patients and increase costs to the government in order to add to the already high profits of pharmaceutical companies.

Support for Program Integrity Efforts to Strengthen 340B

The AHA supports program integrity efforts to ensure that the 340B program remains available to safety-net providers. Hospitals that participate in the 340B program are subject to oversight by HRSA's Office of Pharmacy Affairs, and hospitals in the 340B program must meet numerous program integrity requirements. These include yearly recertification; audits from both HRSA and drug manufacturers; and maintaining auditable inventories of all 340B and non-340B prescription drugs. In recent years, HRSA implemented additional program integrity efforts, and the AHA encourages HRSA to develop a process to help financially distressed providers meet the new program integrity provisions.

Expansion of 340B to Benefit Hospitals, Taxpayers

The AHA supports expanding the 340B program to the inpatient setting, as it would be a "win-win" for taxpayers and hospitals. It would generate savings for the Medicaid program by requiring hospitals to share with Medicaid a percentage of their savings on inpatient drugs administered to Medicaid patients. It also would reduce Medicare costs, as CAHs are paid 101 percent of their inpatient and outpatient costs by Medicare, and the 340B pricing mechanism would lower CAHs' drug costs. According to the Congressional Budget Office, expanding the program to cover inpatient services would save the federal government upwards of $1.2 billion over 10 years.

Support for HRSA in Orphan Drug Case

The AHA supports HRSA's implementation of the orphan drug policy and has filed friend-of-the-court briefs in support of HRSA. The Pharmaceutical Research and Manufacturers of America has mounted a legal challenge to block HRSA from implementing a policy that allows rural and cancer 340B hospitals to purchase "orphan drugs" through the 340B program. HRSA's policy allows these hospitals to purchase orphan drugs through the 340B program when the drugs are not used to treat the rare conditions for which the orphan drug designation was given.

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[1] Forbes, BBC News, Pharmaceutical Industry gets high on fat profits. November 6, 2014. *http://www.bbc.com/news/business-28212223*.