



GOALS AND OBJECTIVES

A STRONG VISION FOR CHANGE

America's hospitals support the comprehensive approach to long-term change outlined in *Health for Life: Better Health. Better Health Care*. This framework for reform, initiated by the AHA, identifies five essential goals and how to achieve them: a focus on wellness; the most efficient, affordable care; the highest quality care; the best information; and health coverage for all, paid for by all. The association is forging a broad-based, national coalition to work for the public policy and private-sector actions needed to reach these goals. Hospitals' vision for change also is rooted in their internal *Pursuit of Excellence* as they work to deliver care that is safe, timely, efficient, effective, equitable and patient-focused.

A CLEAR FOCUS ON TODAY'S ISSUES

At the same time, the AHA is committed to advocating vigorously for the resources hospitals need to do their best for patients and communities in today's fragile environment. That means working with Congress, the executive branch, and the courts to:

- Improve **quality and patient safety**.
- Protect **fair reimbursement** to ensure that beneficiaries of government-funded health programs like Medicare and Medicaid receive the highest-quality health care services.
- Improve the health care **delivery system**.
- Ensure accountability **for tax-exempt status**.
- Increase the capacity of the health care **workforce** and enhance employee relations.
- Guarantee a **fair marketplace** that does not jeopardize the essential health care services America's communities need.

HEALTH FOR LIFE

Our nation has what it takes to offer the best in health care: leading-edge technology; highly trained practitioners; and care provided 24 hours a day, seven days a week. Every year, America's hospitals care for 118 million patients in their emergency departments. They treat 600 million out-patients, perform 27 million surgeries, and bring 4 million babies into the world.

And the demand for hospital care will soar as 78 million Baby Boomers reach retirement age. Meanwhile, an estimated 62 percent of individuals between the ages of 50 and 64 have at least one chronic condition, a number expected to increase as the population ages. At the same time, 47 million people in America lack health care coverage. Health insurance premiums have risen 87 percent over the past six years. In 2006 alone, employer health insurance premiums rose by 7.7 percent – more than twice as fast as workers' wages (3.8 percent) and overall inflation (3.5 percent).

The need for change is clear, and the 2008 elections offer an historic opportunity for every American to push health care to the top of the candidates' agendas. The presidential race is wide open because, for the first time in 80 years, there is no incumbent president or vice president running for the White House. At the same time, 33 senators will be elected, along with the entire House of Representatives. The AHA's *Campaign 2008* strategy will ensure that the hospital voice is heard in this year's political campaigns.

The AHA is committed to involving everyone with a stake in better health to collectively develop innovative ideas for change. With the input and participation of many in the hospital field, the AHA has developed a framework for health care reform called *Health for Life: Better Health, Better Health Care*. It's not a "hospital plan" for reform but, rather, a roadmap for the American public to reach the goal of health care that is accessible, affordable and of the highest quality.

The framework is built on five essential elements:

- **Focus on Wellness** – Good health – physical, mental and oral – is essential for a productive and vibrant America. A focus on wellness must be integrated into the lifecycle, from birth to death, and be encouraged in our homes, schools, workplaces, and communities.
- **The Most Efficient, Affordable Care** – Americans will not be satisfied unless and until the cost of insurance and the cost of health care are affordable.
- **The Highest Quality Care** – Motivate doctors, nurses, hospitals, nursing homes, and others to work together and team up with patients and families to make sure the right care is given at the right time and in the right setting.
- **The Best Information** – Good information is the gateway to good care.
- **Health Coverage for All, Paid For By All** – Health coverage for all is a shared responsibility. Everyone – individuals, business, insurers and governments – must play a role in both expanding coverage and paying for it.

Major changes to our health care system have been proposed and failed in the past. They failed, not for lack of credibility, but because politics got in the way of reason and action. The changes envisioned by the people of America's hospitals will not be achieved by one political party simply out-voting the other. The only path to a better future is through a deliberate, bipartisan process, where multiple views can be expressed, debated, refined ... and brought to action.

Addressing the issue of health care affordability, in particular, will require priority attention. The AHA will develop a strategy that educates the public about the underlying reasons for cost growth, the value of health care as an investment, and the costs of regulation; offers solutions to reduce the growth in health care spending; and highlights how hospitals have reduced the cost of care and have increased value.

THE ANNUAL BUDGET PROCESS

- **PRESIDENT'S BUDGET/CONGRESSIONAL BUDGET RESOLUTION**

Medicare reimburses hospitals only 91 cents for every dollar of care they provide to a Medicare patient. Medicaid payments are worse, reimbursing only 86 cents for each dollar of services. In 2006 alone this combined underpayment totaled \$30 billion. Yet, the president's budget for fiscal year (FY) 2009 proposes nearly \$200 billion in new cuts in those programs over the next five years.

Part of these proposed cuts is a response to a requirement in the *Medicare Modernization Act (MMA) of 2003*. Under the MMA, Medicare's trustees estimate the ratio by which Medicare program expenditures are expected to exceed dedicated revenue (from the general treasury used to support Medicare). If the trustees project, for two consecutive years, that the ratio will exceed 45 percent within seven years, a determination of "excess general revenue funding" is issued. That triggers a process by which the president and Congress must respond to the warning. In their 2007 annual report, the Medicare trustees issued the first Medicare funding warning when, for the second year in a row, they projected that the 45 percent threshold would be exceeded within seven years, specifically by 2013. As a result, within 15 days after submitting his budget proposal for FY 2009, the president must submit legislation to Congress responding to the warning. An expedited process is in place for Congress to consider the president's legislation. The reductions in the president's budget recommendation are at least in part a response to the "45 percent trigger."

The Medicare funding warning does not automatically bring about spending reductions or other changes in the program. Legislation to address the situation must be passed by Congress and signed by the president.

The AHA opposes the 45 percent trigger because it is an arbitrary mechanism to reduce Medicare funding at a time when more and more people rely on the program for their care. The Medicare provisions of the *Child Health and Medicare Protection Act of 2007 (CHAMP Act)*, which passed the House, included an AHA-backed provision that would repeal the trigger. We will continue to oppose the use of this trigger, and any other reductions that threaten the hospital services America's children, elderly and disabled rely on.

- **FY 2009 APPROPRIATIONS BILLS**

The AHA will work to ensure continued federal funding for grant programs that support:

- Nursing and health professions education and training;
- Children's graduate medical education;
- Rural health programs;
- Emergency preparedness;
- Maternal and child health block grant;
- Substance abuse/mental health block grant;
- Health information technology;
- Medical and health services research; and
- The National Quality Forum.

- **MEDICARE AND MEDICAID PACKAGE (RECONCILIATION)**

The AHA will work to extend Medicaid provisions expiring May 25:

- The current block on regulations issued by the Centers for Medicare & Medicaid Services (CMS) that would restrict the use of intergovernmental transfers and certified public expenditures. CMS also would eliminate Medicaid support of graduate medical education. Such regulations would jeopardize funding for services provided to the elderly, poor and disabled served by the program.

In addition to pursuing legislative strategies to block these regulations, the AHA and our allied hospital associations will also undertake a litigation strategy to prevent the implementation of these rules.

The AHA will work to extend Medicare provisions expiring June 30:

- The prevention of Medicare payment **cuts to physicians**.
- Allowing independent labs to bill Medicare directly for the technical component of certain physician **pathology services** furnished to hospital patients.
- Allowing cost-based payment for **rural laboratory services** provided by hospitals with fewer than 50 beds in certain low-population areas.
- The exceptions process for **therapy caps**.
- **Section 508** wage index classifications (expires 9-30-08).

These Medicare provisions are likely to be considered in 2008:

- **Value-based purchasing:** Congress is expected to consider options for pay-for-performance based on a recent report from CMS. The AHA will work to shape this effort using our *Principles for Using Payment to Reward Performance* (available to AHA members at <http://www.aha.org/aha/about/Organization/board-actions.html>), with a focus on utilizing measures selected by the Hospital Quality Alliance as a platform, and ensuring that the approach is not used as a backdoor method to arbitrarily reduce payment for hospital services.
- **Self-referral to physician-owned hospitals:** The AHA supports the House-passed provision of the CHAMP Act that eliminates the whole-hospital exception for physician self-referral under current law, and grandfathers existing facilities with certain restrictions.
- **Rural package:** The AHA supports further efforts to protect critical access hospitals (CAHs), such as expanding cost-based payment to other settings; allowing flexibility for bed size and relocation; ensuring that CAHs that contract with Medicare Advantage plans are appropriately reimbursed; and allowing CAHs to utilize reference labs to provide services to their Medicare patients. The AHA also recommends cost-based payment for rural hospitals with 50 beds or fewer, and supports restoring the full value of the outpatient hold-harmless provision to small rural and sole community hospitals.
- **Medicaid and SCHIP:** The AHA supports a moratorium on a CMS directive issued August 17, 2007 that would block states from extending Medicaid and the State Children's Health Insurance Program (SCHIP) to children in families with income above 250 percent of the federal poverty line (FPL) without first showing that 95 percent of those eligible below 200 percent of FPL have been enrolled in the program.
- **Accreditation:** The AHA will monitor provisions that would change the method by which the federal government contracts with The Joint Commission, which could require use of the Medicare Conditions of Participation as their standards for accreditation of hospitals.
- **Medical education:** The AHA supports efforts to increase the capacity to train more physicians by increasing the number of graduate medical slots authorized under Medicare.

Other items on the hospital agenda:

- **Recovery audit contractors (RACs):** The AHA supports legislation to halt the RAC program for one year. *The Medicare Recovery Audit Contractor Program Moratorium Act* (H.R. 4105) also would require both CMS and the Government Accountability Office to produce reports evaluating RAC performance in the three

pilot states (California, Florida and New York). A pause in implementation of the program would provide CMS the time needed to address many problems identified by hospitals. The AHA and its allied hospital associations have developed a detailed list of recommendations that should be considered.

- **Local coverage determinations (LCDs):** The AHA supports removing overly restrictive LCDs for rehabilitation services by requiring that fiscal intermediaries use national guidelines to determine medical necessity. A provision in the Preserving Patient Access to Inpatient Rehabilitation Act (H.R.1459/S.543) addresses this matter.
- **340b drug discount program:** The AHA supports making access to the 340b outpatient drug discount program available to inpatient and outpatient services for certain rural hospitals, including CAHs. Also, we support expansion of the program to inpatient services for Medicare disproportionate share hospitals (DSH).
- **Pay-go defense:** Under congressional “pay-go” rules, new mandatory spending programs or taxes must be offset by an equal amount of mandatory spending reductions and/or new revenues. Reductions in the hospital update factors for the Medicare inpatient and outpatient prospective payment systems, and cuts in the Medicare indirect medical education adjustment, could be targeted as offsets. We will oppose any effort to offset funding on the backs of hospitals and the patients and communities they serve.

THE ANNUAL REGULATORY PROCESS

• **FY 2009 INPATIENT PROSPECTIVE PAYMENT SYSTEM RULE**

This regulation will determine the rates Medicare pays for inpatient hospital services beginning October 1, 2008. It is expected to expand the list of situations in which there would be no higher diagnostic-related group (DRG) payment for adverse events, and to revise measures for the reporting of quality. It also may propose cutting DSH capital payments and signal plans for further implementation of the “behavioral offset,” which CMS would use to eliminate what it claims will be the effect of greater use of coding for complications and co-morbidities as hospitals move to a new DRG system. In addition, the rule is expected to include proposals to change the area wage index (AWI). The AHA will monitor and seek to influence development of all of these matters. A task force of state, regional and metropolitan hospital association leaders will develop options for the field to consider on the AWI.

• **CY 2009 OUTPATIENT PROSPECTIVE PAYMENT SYSTEM RULE**

This regulation will determine the rates Medicare pays for hospital outpatient services beginning January 1, 2009. It also is expected to include revised measures for quality reporting.

• **RECOVERY AUDIT CONTRACTORS**

In addition to our legislative strategy, the AHA has a list of specific improvements we will urge CMS to make that can ensure the RAC program is implemented fairly, with appropriate due process. We also will work very closely with state hospital associations to develop strategies to help hospitals prepare for the RAC process.

• **MEDICARE DSH CALCULATION**

Questions have been raised about the accuracy of the formula CMS uses to calculate Medicare DSH payments for hospitals serving large percentages of low-income people.

As CMS determines how to address the issue, we will work to ensure that the solution is fair for these hospitals and the patients who depend on them.

- **OTHER KEY ANNUAL REGULATIONS**

The AHA also will work with hospitals and CMS in the development of other annual regulations establishing FY 2009 payment rates for rehabilitation, psychiatric care, home health, skilled nursing facilities and long-term care hospitals.

OTHER PRIORITY ISSUES

- **QUALITY AND PATIENT SAFETY**

- **Hospital Quality Alliance (HQA):** The AHA will continue to participate in and support the HQA as the platform for providing the public with information about hospital quality. This includes working with the National Quality Forum to shape national quality goals.
- **Serious, adverse events:** The AHA will work with state, regional and metropolitan hospital associations to help hospitals voluntarily adopt principles developed and adopted by the AHA on this matter.
- **Infection control:** The AHA supports implementation of HQA measures regarding surgical infection prevention, and will work with other stakeholders to undertake a public-private sector effort to address infections.
- **Patient safety organizations (PSOs):** The AHA supports the regulatory process to establish PSOs and allow hospital systems, hospital associations and related organizations to serve as PSOs, as authorized under current law.
- **Racial and ethnic disparities:** The AHA supports efforts to reduce disparities in health outcomes by targeting clinical practices, health professions education and research. We also support data collection efforts that better identify and address disparities and use best practices to help others reduce disparities. The AHA's work on this issue will be informed by our Special Advisory Group on Improving Hospital Care for Minorities.
- **Information technology (IT):** We will continue efforts to ensure that health information technology is utilized to improve care and achieve efficiencies. We will work to:
 - ▲ Modernize the “**Stark Laws**” so hospitals can help physicians integrate electronic health records; build on CMS regulations that are a good first step in this direction; and help the Internal Revenue Service recognize the public benefit of such activities;
 - ▲ Develop ways to help hospitals fund IT implementation, and;
 - ▲ Continue to work with key stakeholders to select open, **interoperable standards** to facilitate the use of health IT.
- **ICD-10:** We will work to implement ICD-10 in an expeditious manner and avoid any efforts to delay the process.

- **COVERAGE**

As outlined above, protecting SCHIP and Medicaid from budget reductions and eligibility restrictions is key to ensuring that coverage for certain vulnerable populations is not eroded. In addition, the AHA will take the following actions:

- **SCHIP:** We will continue to monitor the SCHIP program, which was extended until March 2009, to ensure that adequate funding levels are maintained.
- **Parity:** We will continue to support efforts to create equal health insurance coverage for mental and physical illnesses. This includes mental health parity requirements under current law, which expired last year.
- **Cover the Uninsured Week:** We will continue our leadership role and partnership in the Cover the Uninsured Week initiative, now in its sixth year, with other national organizations.

- **DELIVERY SYSTEM IMPROVEMENTS**

- **Clinical integration:** The AHA will pursue strategies that allow better alignment of incentives for quality and efficiency in a manner that also permits providers to compete more effectively.
- **Health plan consolidation:** The AHA will analyze the consolidation of the health insurance industry and the standards under which mergers are reviewed by federal and state antitrust authorities to ensure that markets remain competitive and that hospitals are not disadvantaged during negotiations as a result of health insurers' accumulation of market power.
- **Section 1011:** The AHA will work to reauthorize this program that provides assistance to hospitals that serve high volumes of undocumented immigrants in their emergency departments.
- **Disaster relief:** The AHA is working with a special advisory group of hospitals and allied hospital associations that have experienced a variety of disasters resulting in damage not only to hospitals but to the infrastructure of their entire community. The goal is to establish systematic response approaches that improve on current ad-hoc approaches.
- **Gainsharing:** The AHA will support efforts to modernize gain-sharing laws to allow greater flexibility for hospitals and physicians to share financial incentives that are designed to improve quality.
- **Ambulatory surgery centers (ASCs):** To protect quality and patient safety, the AHA will work to ensure appropriate regulation of what procedures can and cannot be performed in an ASC.
- **Emergency Medical Treatment and Active Labor Act (EMTALA)/physicians on-call:** The AHA will support strategies that modernize EMTALA, including facilitating hospitals' ability to comply with the requirements by providing incentives for physicians to assist hospitals in meeting these obligations.
- **Price transparency:** The AHA continues to support building on the efforts of the 32 states that already have price transparency policies in place by supporting legislation that would require those states that have not adopted strategies to do so by a certain date or face federal requirements. The AHA also will work to ensure that transparency requirements apply to all sectors of the health care field.

• TAX-EXEMPT STATUS

- **Form 990:** The AHA will help hospitals comply with the revised Form 990 and related schedules recently issued by the IRS. In addition, we will work with the IRS to develop instructions that effectively assist hospitals in completing these forms.
- **Community benefit:** The AHA will continue to provide member hospital leaders with tools and best practices that can help them with community benefit assessment and reporting, and with compliance with AHA guidelines on billing and collection practices, including policies on providing discounts to the uninsured of limited means.
- **Community Connections:** Utilizing its *Community Connections* program and other creative strategies, the AHA will continue helping hospitals reaffirm their rightful place as a vital and valued community resource that merits broad public support. [Note: These initiatives are not restricted to or only appropriate for tax-exempt hospitals. Investor-owned and government-owned hospitals also are encouraged to utilize them.]

• WORKFORCE

- **Supply and Capacity**
 - ▲ **Nurse Education Act:** In addition to ensuring adequate appropriations for federal programs that support nursing education and health professions education, the AHA supports the reauthorization of the Nurse Education Act. The programs authorized under this law, which expires this year, should be modified to increase support for additional faculty to educate more nurses.
 - ▲ **Conrad 30:** The AHA also supports immigration laws that allow flexibility to employ foreign-trained nurses, as well as the reauthorization of the Conrad 30 program that permits recruitment of physicians to rural areas.
- **Labor and Staffing**
 - ▲ **Elections and flexibility:** The AHA supports legislation that would maintain current law under which labor unions must organize workers through a free and open election process supervised by the National Labor Relations Board (NLRB).

The AHA also supports retaining management flexibility (i.e., staffing ratios and overtime policies) to ensure that patients receive the care they need at all times. In addition, the AHA supports recent NLRB decisions that better define those employees who operate in a supervisory capacity. We would oppose legislation to reverse such rulings.

- ▲ **Corporate campaigns:** The AHA also will continue to implement a strategy to help hospitals faced with corporate campaigns undertaken by labor unions. This strategy includes developing tools to help hospitals understand the nature of these campaigns, providing opportunities to learn from those who have encountered these efforts, and seeking legal opportunities to protect the rights of employers.