

# Value of Membership

November 2012

## Ensuring Needed Resources

In these deficit reduction-focused times, AHA worked hard to protect funding for hospital services from arbitrary cuts, successfully defeating several attempts by Congress and the Administration to cut payments for outpatient evaluation and management services and to restrict the use of state provider taxes. Among other victories, AHA:

- **Proposed Documentation and Coding Cut.** Convinced the Centers for Medicare & Medicaid Services (CMS) to rescind a proposed new 0.8% cut to inpatient prospective payment system (PPS) payments to permanently eliminate what the agency claimed was the effect of documentation and coding changes from fiscal year (FY) 2010 that the agency said do not reflect real changes in case mix.
- **Medicare Physician Payment.** Worked with Congress to prevent a 27.4% cut to Medicare physician payments in calendar year (CY) 2012.

## Reducing Red Tape

Outdated regulations, duplicative or conflicting rules, unworkable timelines – all of these increase the burden on providers and draw much-needed resources away from patient care. In 2012, AHA fought for streamlined regulations, common sense rules and manageable timelines. Among other achievements, AHA:

- **Medicare Conditions of Participation (CoPs).** Successfully urged CMS to revise many outdated CoPs for hospitals and critical access hospitals (CAHs). The improvements included allowing a multi-hospital system with multiple Medicare numbers to operate with a single governing board and permitting CAHs to provide certain services (diagnostic, therapeutic, laboratory, radiology and emergency services) under service arrangements; previously, CAHs were required to provide these services directly. However, CMS also finalized a provision that had never been proposed – requiring hospital governing boards to include a medical staff member. AHA urged CMS to immediately rescind this new requirement for a number of reasons, such as the fact that some hospitals have boards that are elected or appointed. CMS decided not to enforce the new provision and will instead review it in future rulemaking. In addition, AHA will continue advocating for CMS to allow multi-hospital systems with multiple Medicare numbers to operate with a unified medical staff.
- **Outpatient Supervision.** Convinced CMS to extend for an additional year the delay in enforcement of direct supervision requirements for CAHs and small, rural hospitals. CMS also added four new voting members to the Advisory Panel on Hospital Outpatient Payment to represent CAHs and rural hospitals. Since the beginning of the year, CMS has approved 27 services for general supervision and issued preliminary approval for 15 more.

**In one of the most divisive political climates** in recent memory, the American Hospital Association (AHA) worked across party lines – with Congress, the regulatory agencies and the courts – to give voice to the interests of the hospital field.

Below you'll find just a few highlights of the ways the AHA has been working for you so far in 2012. You can find even more at [www.aha.org](http://www.aha.org) under "Value of Membership."

**We think you'll agree, when we work together, we can accomplish a great deal.**

**In the year ahead, that unity will be needed more than ever. We are honored that you have chosen us to represent you, and we look forward to your continued support and involvement.**



**Rich Umbdenstock**  
President and CEO

- **Stage 2 Meaningful Use.** Secured a delay in the start of the Stage 2 meaningful use requirements under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs until FY 2014 for hospitals and a shorter reporting period in FY 2014 to ensure a safe and orderly transition from Stage 1 to Stage 2. AHA also convinced CMS to allow CAHs to include capital lease costs as allowable costs when calculating incentive payments.
- **ICD-10 Delay.** Successfully urged CMS to delay the deadline for implementing ICD-10 diagnosis and procedure codes to Oct. 1, 2014.
- **Electronic Transfer of Health Care Funds.** Convinced CMS to finalize the adoption of federal standards for the electronic transfer of health care funds and remittance advice under the *Health Insurance Portability and Accountability Act*.
- **Emergency Medical Treatment and Labor Act (EMTALA).** Convinced CMS not to expand the current EMTALA regulations. The agency said that a hospital has satisfied its EMTALA obligation when it admits an individual "in good faith in order to stabilize the [emergency medical condition]."
- **Long-term Acute Care Hospital (LTCH) '25% Rule.'** Successfully urged CMS to delay full implementation of the "25% Rule" for one year for cost reports beginning between Oct. 1, 2012 and Oct. 1, 2013. LTCHs with cost reports beginning between July 1 and Sept. 30, 2012 will no longer have to wait until next year for relief from full implementation of the 25% Rule.
- **Rehabilitation and Respiratory Care Services.** Successfully urged CMS to rescind interpretive guidance pertaining to rehabilitation and respiratory care services under the hospital CoPs, issuing revised guidance that allows non-privileged practitioners to order outpatient rehabilitation and respiratory care services in accordance with state license/scope of practice and written hospital policy.

- **Inpatient Rehabilitation Facility (IRF) Local Coverage Determination (LCD).** Convinced a Medicare Administrative Contractor to rescind a draft LCD that would have prohibited payment for certain IRF patients with certain lower extremity joint replacements.
- **Outpatient Quality Measure OP-16.** Successfully urged CMS to remove OP-16 from the CY 2013 outpatient quality reporting program based on patient safety concerns.
- **Pension Contribution Rules.** Worked with Congress to pass legislation that included changes to pension contribution rules. As a result, pension plan liabilities will continue to be determined based on corporate bond segment rates, which are based on the average interest rates over the preceding two years.

## Supporting Rural Health Care

Government payment systems often fail to recognize the unique circumstances of small, rural hospitals. Among other efforts, AHA:

- **Medicare Extenders.** As part of the Medicare physician fix bill in February, worked with Congress to extend several provisions of importance to small and rural hospitals, including: Section 508 hospital wage index reclassifications; the outpatient hold-harmless provision for rural hospitals and sole community hospitals (SCHs) with no more than 100 beds; payments for the technical component of certain physician pathology services; and ambulance add-on payments.
- **SCHs.** Convinced CMS to substantially modify its SCH policy to be consistent with existing regulations. CMS had proposed to clarify that it can revoke SCH classification retroactive to when it was first granted if it determines a hospital was incorrectly classified as an SCH.

## Preparing the Next Generation of Health Care Providers

The ability of teaching hospitals to train the next generation of physicians is crucial to the future success of the American health care system. Among other victories, the AHA:

- **New Teaching Hospitals.** Worked with CMS to finalize a policy to increase the cap-building period for new teaching hospitals from three to five years. CMS also modified its proposal so that only unused slots at the end of the five-year period will be removed.
- **Children's Hospitals Graduate Medical Education (CHGME).** Successfully urged 141 members of the House and 29 senators to ask appropriators to provide freestanding children's hospitals with adequate funding to train medical residents in FY 2013. The president's FY 2013 budget proposed cutting CHGME by two-thirds.
- **Conrad State 30 J-1 Visa Waiver Program.** Worked with Congress to approve legislation extending through September 2015 the Conrad State 30 J-1 visa waiver program, which allows foreign-born physicians to remain in the U.S. for three years after medical school to serve in medically underserved areas.

## Combating Drug Shortages

After strong advocacy by AHA and a coalition of health care stakeholders, Congress passed the *Food and Drug Administration Safety and Innovation Act*, which included provisions to help alleviate critical drug shortages. The law:

- requires drug makers to report production interruptions and discontinuations to the FDA in advance;
- codifies FDA's authority to speed approval of applications to make drugs in short supply;
- lifts caps on narcotic ingredients to ensure sufficient supply for anesthesia, pain management and other critical uses; and
- improves communications with providers and patients about the reason for potential drug shortages and how long they may last.

The law also creates a user fee program that will help speed FDA approval of generic drugs, and allows hospitals within health systems to conserve their inventory of shortage drugs by sharing repackaged drugs.

## Implementing the Patient Protection and Affordable Care Act (ACA)

At the urging of AHA and other national hospital groups, the Supreme Court in June ruled the ACA's individual mandate and Medicaid expansion constitutional. However, the court struck down the penalty for a state declining to expand its Medicaid program (withholding all federal Medicaid funds). States that participate in the Medicaid expansion will receive the federal financial support included in the ACA. AHA will continue to press the Department of Health and Human Services for guidance as ACA implementation moves ahead.

## Improving Health Care Quality

Hospitals participating in the national *On the CUSP: Stop BSI* project reduced Central Line-associated Blood Stream Infections (CLABSI) in adult ICUs by 40% over four years, saving more than 500 lives and \$34 million in health care costs. Led by the AHA's Health Research & Educational Trust (HRET) affiliate and supported by the Agency for Healthcare Research and Quality, the CUSP project has helped participating hospitals reduce the rate of CLABSI nationally to 1.1 per 1,000 central line days in 2012 from 1.9 in 2009. More than 1,100 hospitals from 44 states, the District of Columbia and Puerto Rico are currently enrolled in the national effort, which builds on the success of an earlier Michigan Health & Hospital Association Keystone Center project.

HRET also was recently awarded a contract by CMS to support its Partnership for Patients campaign, a public-private partnership that intends to help improve the quality, safety and affordability of health care for all Americans. As a Hospital Engagement Network (HEN) with nearly 1,800 hospital members recruited by its 33 state hospital association partners, HRET will help identify solutions already working to reduce health care-acquired conditions, and establish ways to spread them to other hospitals and health care providers.