



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. You can find even more at www.aha.org under "Value of Membership."

We think you'll agree, when we work together, we can accomplish a great deal. In the times ahead, that unity will be needed more than ever. We are honored that you have chosen us to represent you, and hope that the AHA can rely on your continued support.

Ensuring Needed Resources

In these deficit reduction-focused times, the AHA worked hard to protect funding for hospital services from arbitrary cuts, successfully defeating several attempts in Congress to cut payments for hospital services, including the proposed implementation of site-neutral payments for outpatient services, cuts to graduate medical education and bad debt, and changes to the critical access hospital (CAH) program. In addition, AHA lobbied on the following issues:

- **Medicaid Disproportionate Share Hospital (DSH) payments.** Worked with Congress to delay scheduled cuts to Medicaid DSH payments for the next three years.
- **Medicare DSH.** Helped persuade the Centers for Medicare & Medicaid Services (CMS) to reduce the size of the overall Medicare DSH cut in fiscal year (FY) 2014 from a proposed \$1 billion to \$550 million. CMS also will distribute uncompensated care DSH payments on a per-discharge (rather than periodic interim) basis, avoiding a potential cut in Medicare Advantage payments to hospitals of about \$3 billion annually. Worked with CMS to revise cost reporting procedures to align the uncompensated care DSH payments with each individual hospital's cost reporting period. We continue to urge Congress to delay the Medicare DSH cuts contained in the Affordable Care Act (ACA).
- **Two-midnight policy.** Secured several partial legislative and regulatory enforcement delays of CMS's two-midnight policy for inpatient admission and medical review criteria. Under the enforcement delay, recovery auditors and other Medicare review contractors will not conduct post-payment patient status reviews of inpatient hospital claims with dates of admission on or after Oct. 1, 2013 through March 31, 2015. AHA continues to urge CMS to fix the critical flaws of the underlying policy by immediately engaging stakeholders to find a workable solution that addresses the reasonable and necessary inpatient-level services currently provided by hospitals to Medicare beneficiaries that are not expected to span two midnights.
- **Rebilling.** At the urging of AHA and others, CMS recognized that physical therapy, speech-language pathology and occupational therapy services were incorrectly classified in its proposed rebilling rule as services requiring outpatient status, and revised the final rule accordingly to permit hospitals to rebill them.
- **Medicare physician payment.** Worked with Congress to prevent a 24% cut to Medicare physician payments that was scheduled to take place Jan. 1 through April 1, 2015.

- **Extension of Medicare provisions:** As part of the most recent Medicare physician payment fix, AHA worked with Congress to extend several provisions of importance to hospitals through April 1, 2015, including: ambulance add-on payments, the enhanced low-volume adjustment, the Medicare-dependent hospital program, and the outpatient therapy cap exceptions process.
- **Outpatient Prospective Payment System:** Helped persuade CMS to delay implementing the comprehensive ambulatory payment classifications until calendar year (CY) 2015 due to insufficient and erroneous data impacts in the proposed rule. The additional time will allow for public review and comment as well as review by CMS's Advisory Panel on Hospital Outpatient Payment. CMS also made a number of other modifications to its proposed rule in response to AHA's advocacy efforts, including not collapsing the 10 emergency department visit codes into a single code in CY 2014 and modifying some of its packaging proposals.

Reducing Red Tape

- **Recovery Audit Contractors (RAC).** Along with limitations on RACs related to the two-midnight policy, in response to concerns voiced by AHA, CMS is making a number of changes to the RAC program, effective with the next round of contracts. CMS will encourage use of the pre-appeal discussion period to resolve disputes over RAC audits by requiring RACs to promptly acknowledge hospitals' requests for a discussion. Further, CMS will prohibit RACs from referring denied claims for recoupment until at least 30 days has passed, so that hospitals are not forced to choose between using the discussion period and appealing the claim. CMS also will establish limits on the number of medical records RACs can review based on claim type, and will adjust hospitals' medical records limit based on error rate. Also, in January, AHA launched a new online tool that allows hospitals to compare the impact of Medicare's RAC program based on RAC region, bed size, ownership status and other variables. Hospitals can use the RACTrac Analyzer with AHA's existing RACTrac survey to create reports that compare their hospital's RAC activity with those of similar hospitals.
- **Medicaid presumptive eligibility.** Convinced CMS to clarify that hospitals can continue to use service vendors to assist them in making Medicaid presumptive eligibility determinations under the ACA.
- **Disasters and quality reporting.** Helped persuade CMS to allow hospitals in declared disaster zones 90-days, rather than 30-days, to file a waiver from the value-based purchasing program.

- **Stage 3 meaningful use.** Secured a delay until FY 2017 for the start of Stage 3 requirements for meaningful use of electronic health records (EHR) under the Medicare and Medicaid EHR Incentive Programs. AHA welcomed the one-year delay in the Stage 3 start date, and continues to work to address its more immediate concerns with Stage 2. AHA also helped secure an expanded hardship exception for penalties for failure to meet meaningful use that began in FY 2015.
- **EHR and Method II Billing.** Convinced CMS to take steps to ensure that certain physicians who provide services in outpatient departments of CAHs are eligible to participate in the Medicare EHR Incentive Program beginning in 2013. Secured extra time for physicians to complete their online attestations for meaningful use, and a one-time window for hospitals to attest to meeting meaningful use after the deadline for FY 2013.
- **Protections for health information technology (IT) donations.** Consistent with AHA input, CMS and the Department of Health and Human Services (HHS) Office of Inspector General extended through 2021 the regulatory protections under the Stark and antikickback laws for health IT donations from hospitals to physicians. The protections were set to expire in 2013. AHA continues to urge the agencies to make the protections permanent.
- **Medicare Conditions of Participation (CoPs).** Successfully urged CMS to revise many outdated CoPs for hospitals and CAHs. The improvements included 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. AHA continues to advocate that CMS allow multi-hospital systems to operate with a unified medical staff, if they so choose.
- **Hospital Mortgage Insurance Program.** Worked with Congress to extend until July 31, 2016, the exemption from the so-called “patient day test” for CAHs under the Federal Housing Administration’s Hospital Mortgage Insurance Program (Section 242). Congress recognized the limitations of the “patient day test” as it applied to CAHs, and exempted them from its requirements in 2006. That exemption had expired on July 31, 2011.
- **Long-term care hospital (LTCH) reform.** CMS will begin to roll out in October 2015 patient admissions criteria for LTCHs that were enacted by Congress. While stringent, the new criteria will provide regulatory stability that serves as a bridge to future delivery system reforms. In addition, the criteria were accompanied by four years of much needed “25% Rule” relief.
- **Inpatient rehabilitation facilities (IRF).** Consistent with AHA input, in the IRF final rule for 2014, CMS reduced the volume of codes (from 331 to 261) it proposed for elimination from the “60% Rule” presumptive compliance assessment beginning in FY 2015.

Improving Health Care Quality

- **HRET Hospital Engagement Network.** More than 1,500 hospitals participating in the AHA’s Health Research & Educational Trust (HRET) Hospital Engagement Network improved care for more than 69,000 patients over the past two years while reducing health care costs by nearly \$202 million. Among other improvements, participating hospitals reduced early elective deliveries (which can increase complications) by 57%; ventilator-associated pneumonia by 34%; pressure ulcers by 26%; central line-associated blood stream infections (CLABSIs) in intensive care units by 23%; catheter-associated urinary tract infections (CAUTIs) by 18%; avoidable readmissions for heart failure patients by 13%;

all cause readmissions by 6%; and surgical site infections by 6%. The program is part of CMS’s Partnership for Patients initiative.

- **Good stewardship of health care resources.** An AHA white paper on appropriate use of medical resources includes a “top five” list of hospital-based procedures or interventions that should be reviewed and discussed by a patient and physician before proceeding. Developed with guidance from AHA’s Committee on Clinical Leadership and Physician Leadership Forum, the “Appropriate Use of Medical Resources” white paper builds on the 2013 AHA Board of Trustees report, “Ensuring a Healthier Tomorrow.” In coming months, AHA will release additional resources and best practices to support appropriate use of these procedures and interventions.
- **Quality reporting measures.** Successfully urged CMS to delay until April 1 data collection for three new colonoscopy surveillance and cataract surgery quality measures included in the hospital outpatient and ambulatory surgical center quality reporting programs that will affect payment for CY 2016. AHA asked CMS to delay the Jan. 1 start of data collection because the measure specifications were not yet available.
- **ACA-related patient-safety standards.** Convinced CMS to phase in new patient safety requirements included in the ACA for hospitals with more than 50 beds that wish to contract with Qualified Health Plans in the Health Insurance Marketplaces. The initial phase will begin in January 2015 and is based largely on compliance with the Medicare Hospital CoPs.
- **HRET infection prevention fellowship program.** HRET’s On the Cusp: Stop CAUTI project launched a new leadership development fellowship focused on preventing healthcare-associated infections. Nurses, physicians, and infection prevention and risk management professionals will participate in the 12-month program, which includes in-person and virtual learning events, one-on-one mentoring and improvement projects implemented in the fellows’ organizations. The fellowship is presented in partnership with the Association for Professionals in Infection Control and Epidemiology, Emergency Nurses Association, Society for Healthcare Epidemiology of America and Society of Hospital Medicine.

Preparing the Delivery System of the Future, Today

- **Preparing for the second curve.** The AHA Committee on Research recently outlined strategies to help hospitals and care systems navigate the evolving health care environment. “Your Hospital’s Path to the Second Curve: Integration and Transformation” reviews the environmental pressures driving hospitals and care systems toward greater clinical integration, more financial risk and increased accountability, and provides a framework for leading organizations toward a customized path or series of paths for health care transformation. The report also highlights successful integrated care delivery programs and different forms of integration that can accelerate organizational transformation.
- **Managing the intergenerational workforce.** The latest report from the AHA Committee on Performance Improvement provides hospital leaders with strategies for managing an intergenerational workforce to help achieve the triple aim of better care, better health and lower costs. The strategies found in the report are intended to help hospital leaders build an organizational culture that develops and nurtures employees of all ages and support the AHA’s Hospitals in Pursuit of Excellence initiative.