Transforming the Health Care Delivery System

- Delivery System Reform Programs
- Linking Quality to Payment
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- Enhancing Coverage
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Maintaining Essential Resources

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Reducing Regulatory Burden

- Program Integrity
- Administrative Simplification & ICD-10 Implementation
- Medical Liability Reform
Background

Hospitals, health systems and payers are adopting delivery system reforms to better align provider incentives to improve care coordination and quality, and reduce costs. These reforms include forming accountable care organizations (ACOs), bundling services into discrete 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. On the federal level, many of these activities are being coordinated within the Center for Medicare & Medicaid Innovation (CMMI), which was created by the Patient Protection and Affordable Care Act (ACA). The CMMI, with access to $1 billion annually from 2011-2020, is intended to serve as a vehicle for transforming the delivery and payment of health care services.

AHA View

Our fragmented health care system is rapidly transforming to a delivery system where care is more integrated, providers are at more financial risk, and all elements of the system are more accountable to the public. The AHA is working to ensure that changes to health care delivery are implemented responsibly and improve care for patients and communities. The AHA urges the Centers for Medicare & Medicaid Services (CMS) to establish a reliable evaluation system to assess the impact of all delivery system reform programs and report to Congress on the approaches that warrant broader consideration. These programs should not be automatically implemented by law or regulation. A variety of projects with proper evaluation can determine what best serves patients’ needs. The AHA’s efforts around delivery system reform programs focus on the following:

Accountable Care Organizations. When CMS initially released its proposed rule governing the creation of ACOs under the Medicare Shared Savings Program, the hospital field was very concerned that the agency had created a program that was neither financially attractive nor operationally viable. At the AHA’s urging, CMS made extensive revisions in the final regulation to improve the program. Most significantly, the final rule allows all participants to share in first-dollar savings and eliminates down-side risk for ACOs participating in one option of the program. The AHA also advocated that changes in the ACO program also apply to the CMMI’s Pioneer ACO program. The Pioneer program allows providers to become Medicare ACOs that also have ACO arrangements with one or more private payers. Currently, there are more than 250 ACOs participating in the Medicare Shared Savings Program, representing a mix of hospital and physician-led organizations and covering 4 million lives. The CMMI also has given the green light to 32 Pioneer projects.

In conjunction with the rule, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) issued a final Statement of Antitrust Enforcement Regarding Accountable Care Organizations, abandoning their proposed mandatory antitrust review before hospitals could even apply for the ACO program and...
replacing it with guidance applicable to all ACOs. The guidance said the agencies will “vigilantly” monitor complaints about anti-competitive behavior and all ACOs’ competitive conduct will be evaluated under the “rule of reason,” which takes pro-competitive benefits into account. In addition, CMS and the Department of Health and Human Services (HHS) Office of Inspector General issued an interim final rule with comment period that created five waivers that go beyond the limited protections offered in the proposed rule to provide protection from fraud and abuse laws for hospitals and other providers considering participation in an ACO. While these protections are a good first step, the AHA continues to urge broader federal regulatory reforms to help providers continue the movement toward clinical integration approaches to care delivery (see Clinical Integration section below).

**Bundled Payments.** Bundled payment, where providers are reimbursed a set fee for an episode of care, has the potential to create consistent, efficient high-quality care. Under the ACA, HHS must establish a five-year, voluntary pilot bundling program beginning in 2013 to test different models of bundling to determine what works before broad adoption. The program is to include 10 conditions representing a mix of chronic, acute, surgical and medical conditions. In preparation for the pilot, more than 400 hospitals and health systems have participated in CMMI’s Bundled Payments for Care Improvement initiative. Participants selected one of four different bundling models that range from inpatient-only services, to post-acute only services, to services that span the full care continuum. These organizations will have a six-month risk-free period before making a final decision to continue participation under a risk-based contract or withdraw from the pilot.

The AHA conducted extensive data analysis to help hospitals better understand the intricacies of a bundled payment system and to develop policy recommendations to CMS on the national bundled payment pilot. (Refer to the AHA Issue Brief, “Moving Towards Bundled Payment” for more information.) Chief among the issues addressed include:

- Identifying which episodes are well-suited to payment bundling based on their prevalence and expense to the Medicare program, 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;

- Understanding care pathways including how readmissions and patient placement at discharge affect episode costs.

**State Integration Activities.** The ACA created the Medicare-Medicaid Coordination Office within CMS to improve the quality and efficiency of caring
for dual-eligible beneficiaries. These beneficiaries are low-income seniors and younger persons with disabilities who are enrolled in both Medicare and Medicaid. This population accounts for a disproportionate amount of health care spending in comparison to non-dually eligible Medicare or Medicaid beneficiaries. The Coordination Office’s Financial Alignment Initiative allows states to design and implement demonstration programs to better coordinate care for dual-eligible beneficiaries; 26 states have submitted proposals to CMS. All proposed programs are required to incorporate Medicare and Medicaid primary care, acute care, behavioral health and long-term supports and services through either a capitated or a managed-fee-for-service model. As of March 2013, five states (California, Illinois, Massachusetts, Ohio and Washington) have been accepted to participate, while other states’ applications are under review by CMS.

**Medical Homes.** Medical homes offer a new and promising approach to providing comprehensive primary care to patients in a highly coordinated manner. While not a new concept, medical homes received enhanced attention during the health care reform debate. A provision in the ACA provides grants for capitated payments to primary care providers that organize into interdisciplinary health teams.

**Medicare Medical Homes.** The CMMI’s Comprehensive Primary Care initiative is a multi-payer initiative that offers bonus payments to primary care doctors who better coordinate care for their patients. Primary care practices that choose to participate in this initiative are given resources to better coordinate primary care for their Medicare patients. Currently, there are seven participating sites across the country, representing more than 2,300 providers caring for about 315,000 Medicare beneficiaries.

**Medicaid Medical Homes.** The ACA states that Medicaid beneficiaries are potentially eligible for medical home services if they have two chronic conditions, or have one chronic condition and are at a high level of risk of a second, or have been diagnosed with a mental health condition. States receive a 90 percent federal match rate for medical home services during the first two years a state medical home plan is in effect; states also may receive federal Medicaid matching funds for expenditures up to $500,000 for medical home development activities. Eight states (Idaho, Iowa, Missouri, New York, North Carolina, Ohio, Oregon and Rhode Island) have received federal approval as of March 2013. The majority of states are reimbursing medical homes at a per member per month capitated rate and have encouraged the utilization of health information technology to facilitate care coordination.

**Clinical Integration.** Meaningful health care reform, and the quality and efficiency improvements it promises, is built around the teamwork clinical integration encourages. Current clinical integration efforts span the spectrum from initiatives aimed at achieving greater coordination around a single clinical condition or procedure to fully integrated hospital systems with closed medical
staffs consisting entirely of employed physicians. Over the years, many hospitals have made tremendous strides in improving coordination across the care continuum, while others have been challenged; some hospitals have focused their efforts on privately insured patients to avoid the legal entanglements associated with government reimbursement. Hospitals seeking greater clinical integration first need to overcome the legal hurdles presented by antitrust, patient referral (Stark), civil monetary penalty (CMP) and anti-kickback laws as well as the Internal Revenue Code and many others.

The development of ACOs as part of the Medicare Shared Savings Program marked an historic regulatory effort among several federal agencies to achieve the goal of better coordinated care, as discussed above. While some of the federal agencies (e.g., DOJ-FTC antitrust guidance) made significant strides with respect to ACOs, it is disappointing that none went further to include any clinically integrated arrangements among providers. In fact, in a recent H&HN Daily e-newsletter, a former DOJ acting assistant attorney general in the antitrust division, Sharis Arnold Pozen, called on the FTC and DOJ to issue additional guidance. Pozen urges the agencies to expand antitrust safety zones, clarify bounds of strict per se unlawfulness and evaluate the methodology for defining market share. The AHA continues to urge the agencies to go further and to remove barriers beyond ACOs so all patients have the benefit of clinically integrated care from organizations providing accountable care. The chart on page 5 outlines the various barriers to clinical integration that are the focus of AHA advocacy.
### CHART OF LEGAL BARRIERS TO CLINICAL INTEGRATION AND PROPOSED SOLUTIONS

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<th>Unintended consequences</th>
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<td><strong>Antitrust</strong> (Sherman Act §1)</td>
<td>Joint negotiations by providers unless ancillary to financial or clinical integration; agreements that give health care provider market power</td>
<td>Providers will enter into agreements that either are nothing more than price-fixing, or which give them market power so they can raise prices above competitive levels</td>
<td>Deters providers from entering into precompetitive, innovative arrangements because they are uncertain about antitrust consequences</td>
<td>More comprehensive user-friendly guidance from antitrust enforcers to clarify when arrangements will raise serious issues.</td>
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<td><strong>Ethics in Patient Referral Act (&quot;Stark Law&quot;)</strong></td>
<td>Referrals of Medicare patients by physicians for certain designated health services to entities with which the physician has a financial relationship (ownership or compensation)</td>
<td>Physicians will have financial incentive to refer patients for unnecessary services or to choose providers based on financial reward and not the patient’s best interest</td>
<td>Arrangements to improve patient care are banned when payments tied to achievements in quality and efficiency vary based on services ordered instead of resting only on hours worked</td>
<td>Congress should remove compensation arrangements from the definition of &quot;financial relationships&quot; subject to the law. They would continue to be regulated by other laws.</td>
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<td><strong>Anti-kickback Law</strong></td>
<td>Payments to induce Medicare or Medicaid patient referrals or ordering covered goods or services</td>
<td>Physicians will have financial incentive to refer patients for unnecessary services or to choose providers based on financial reward and not the patient’s best interest</td>
<td>Creates uncertainty concerning arrangements where physicians are rewarded for treating patients using evidence-based clinical protocols</td>
<td>Congress should create a safe harbor for clinical integration programs.</td>
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<td><strong>Civil Monetary Penalty</strong></td>
<td>Payments from a hospital that directly or indirectly induce physician to reduce or limit services to Medicare or Medicaid patients</td>
<td>Physicians will have incentive to reduce the provision of necessary medical services</td>
<td>As interpreted by the Office of Inspector General (OIG), the law prohibits any incentive that may result in a reduction in care (including less expensive products)... even if the result is an improvement in the quality of care</td>
<td>The CMP law should be changed to make clear it applies only to the reduction or withholding of medically necessary services.</td>
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<td><strong>IRS Tax-exempt Laws</strong></td>
<td>Use of charitable assets for the private benefit of any individual or entity</td>
<td>Assets that are intended for the public benefit are used to benefit any private individual, e.g., a physician</td>
<td>Uncertainty about how IRS will view payments to physicians in a clinical integration program is a significant deterrent to the teamwork needed for clinical integration</td>
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<td><strong>State Corporate Practice of Medicine</strong></td>
<td>Employment of physicians by corporations</td>
<td>Physician’s professional judgment would be inappropriately constrained by corporate entity</td>
<td>May require cumbersome organizational structures that add unnecessary cost and decrease flexibility to achieve clinical integration</td>
<td>State laws should allow employment in clinical integration programs.</td>
</tr>
<tr>
<td><strong>State Insurance Regulation</strong></td>
<td>Entities taking on role of insurers without adequate capitalization and regulatory supervision</td>
<td>Ensure adequate capital to meet obligations to insured, including payment to providers, and establish consumer protections</td>
<td>Bundled payment or similar approaches with one payment shared among providers may appropriately be treated as subject to solvency requirements for insurers</td>
<td>State insurance regulation should clearly distinguish between the risk carried by insurers and the non-insurance risk of a shared or partial risk payment arrangement.</td>
</tr>
<tr>
<td><strong>Medical Liability</strong></td>
<td>Health care that falls below the standard of care and causes patient harm</td>
<td>Provide compensation to injured patients and deter unsafe practices</td>
<td>Liability concerns result in defensive medicine and can impede adoption of evidence-based clinical protocols</td>
<td>Establish administrative compensation system and protection for physicians and providers following clinical guidelines.</td>
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This table appears in the AHA TrendWatch report “Clinical Integration – The Key to Real Reform.”
**Background**

Our nation’s health care delivery system is undergoing a major transformation as reimbursement moves from a volume-based methodology to one based on value and quality. By linking hospital reimbursement to achieving positive outcomes on quality measures, the field can better align the health care delivery system toward continuous quality improvement, and provide financial rewards to providers that improve performance.

At the federal level, public reporting of quality measures was initially linked to reimbursement through the Inpatient Quality Reporting program (IQR). Authorized by the 2003 *Medicare Modernization Act* (MMA) and the 2005 *Deficit Reduction Act* (DRA), this “pay-for-reporting” program requires hospitals to report on quality measures in order to receive annual payment updates.

*The Patient Protection and Affordable Care Act* (ACA) significantly raised the financial stakes by creating several “pay-for-performance” programs that reduce Medicare reimbursement to hospitals that score below national performance benchmarks on selected quality measures. Some of the areas measured include readmissions, mortality, patient experience of care, and clinical process measures of heart attack, heart failure and pneumonia care.

**AHA View**

The AHA supports the general concept of linking hospital payments to meeting performance targets on quality measures. **However, we are very concerned that many of the quality measures upon which federal pay-for-performance programs are based do not produce accurate performance results, making them inappropriate to use for public reporting and accountability programs. Moreover, we believe the manner in which some of the payment penalties are calculated lack fairness and equity.** To ensure federal pay-for-performance programs realize their potential, the AHA’s efforts are focused on several fronts:

**Value-based Purchasing (VBP).** Mandated by the ACA, the VBP program pays hospitals for their actual performance on quality measures, rather than just the reporting of those measures, beginning in fiscal year (FY) 2013. The VBP program applies to inpatient prospective payment system (PPS) hospitals, with certain exceptions. It is budget neutral but is estimated to redistribute up to $963 million among hospitals in FY 2013.

The VBP program is funded by reducing all inpatient PPS Medicare-severity diagnosis-related group (MS-DRG) operating payments to participating hospitals by 1 percent in FY 2013, which is then redistributed. This payment reduction gradually increases each year, topping out at 2 percent in FY 2017 and beyond.

**Calculating the VBP score.** Measures must be reported in the hospital IQR for at least one year before they are included in VBP. In FY 2013, the VBP program included 12 clinical quality measures as well as the Hospital Consumer Assessment
of Healthcare Providers and Systems (HCAHPS) patient experiences with care survey. The clinical measures account for 70 percent of a hospital’s VBP score and the HCAHPS survey for 30 percent. The Centers for Medicare & Medicaid Services (CMS) also established “baseline” and “performance” periods for the measures. The agency evaluates each hospital’s scores in the performance period relative to both its baseline period score (i.e., “improvement score”), and to national scores during the performance period (i.e., “achievement score”). Hospitals receive the higher of an “achievement” or “improvement” score for each measure. Individual measures are assigned to one of several “domains” – including process, outcomes, patient experience and efficiency – that have a percentage weight used to calculate the hospital’s total performance score. The total score is used to determine the amount of incentive payment each hospital receives.

The AHA supports the concept of pay-for-performance programs that provide incentives for both demonstrated excellence and noteworthy improvements in patient safety and effectiveness. However, some of the measures selected for use in VBP are deeply flawed, and do not accurately reflect hospital performance. The AHA has expressed particular concern about the following:

- **Reliability of 30-day Mortality and Patient Safety Indicator measures:** Adequate measure reliability ensures that differences in performance scores across hospitals are, in fact, due to underlying differences in quality and not just random variations in patient populations. CMS has included three 30-day mortality measures in this domain for FY 2014. In FY 2015, it will add a claims-based Patient Safety Indicator (PSI). We have urged CMS to remove both the mortality and PSI measures from VBP until they demonstrate an adequate level of reliability. A CMS-commissioned analysis completed in February 2012, showed that both the mortality measures and PSI measure fall well short of the reliability level required of chart-abstracted measures in other programs.\(^1\) Even with two years of data, CMS’s analysis showed that the mortality measures could not meet the “lower limit of moderate reliability.”

- **HCAHPS measures:** We believe CMS should assign a lesser weight to scores from the HCAHPS survey. Emerging research suggests that HCAHPS scores may be impacted by the severity of patient illness more than previously thought. For example, research from the Cleveland Clinic has shown that as patient severity of illness worsens, their HCAHPS scores show a statistically significant decline. The current measures do not fully adjust for this phenomenon, meaning that hospitals may face an unfair, systematic disadvantage in VBP if they care for many severely ill patients.

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The AHA expects that CMS will continue to propose additional measures for use in VBP over the next several years, and may retire or suspend some that have already been adopted once performance on those measures has reached a level that suggests further improvement is unlikely. **The AHA will continue to work with CMS to ensure that the measures selected for use in the hospital VBP are evidence-based, reliable and valid, and are important in improving patient outcomes and efficiency.**

**Hospital Readmission Reduction Program (HRRP).** The HRRP imposes financial penalties on hospitals for “excess” readmissions when compared to “expected” levels of readmissions. The penalty program began on Oct. 1, 2012, and can reduce hospital base Medicare payments by up to 1 percent in FY 2013. The potential penalty increases to 2 percent of base payments in FY 2014, and 3 percent in FY 2015 and beyond. The initial payment penalties are based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare IQR. **The AHA is concerned about both the readmission measures used in the HRRP, and the manner in which the payment penalty is calculated.**

**The current readmission measures do not adequately adjust for socioeconomic factors.** All hospitals, regardless of the circumstances they face, aim to provide the highest quality of care to the patients and families that rely on them. Applying an appropriate adjustment for socioeconomic factors would acknowledge the reality that hospitals cannot always control or change structural barriers to accessing resources that can help prevent readmissions. In some cases, these barriers relate to an incomplete health care infrastructure in those communities. For example, a lack of access to primary care, mental health services, physical therapy and other rehabilitative support can affect readmissions. Other factors can include lack of transportation (which can affect access to medical care), and inconsistent access to nutritious foods. Given the financial impact of the HRRP, we remain concerned that without an adjustment for socioeconomic factors, resources will be taken away from hospitals caring for patients facing the most challenging circumstances. In recognition of these concerns, the Medicare Payment Advisory Commission (MedPAC) intends to further explore the role socioeconomic factors play in readmissions.

**The measures also do not distinguish between related and unrelated readmissions, in spite of the ACA requirement that unrelated readmissions be excluded from measures used in the HRRP.** The AHA successfully advocated for a provision in the law stipulating that readmissions that are unrelated to the original reasons for hospitalization or are planned should be excluded from the calculations of the measures. This distinction is important because it recognizes differences among patients served. CMS has made positive adjustments to these measures to exclude planned readmissions. Disappointingly, the agency has yet to provide a plan for excluding readmissions unrelated to the initial reason for admission.
The AHA also believes that the readmissions penalty formula imposes penalties disproportionate to the costs of excess readmissions. The formula is driven by statute and is quite complex. However, a June 2012 MedPAC analysis demonstrates that, in general, the payment penalty is the product of two elements:

- The “excess cost” of readmissions, which is the DRG payment rate for the condition in the HRRP times an adjusted number of “excess readmissions” for that condition; and
- A “penalty multiplier,” which is equal to 1 divided by the national readmission rate for the condition.²

Using the same simplified example as the MedPAC report, assume that the national readmissions rate for a given DRG is 20 percent. If a hospital has 100 admissions in that DRG, then the expected number of readmissions is 20. If a hospital had 22 actual readmissions, then the number of excess readmissions would be 2. If the base DRG payment was $10,000, and the costs of the readmission were the same as the initial admission, then the cost of excess readmissions would be $10,000 x 2 = $20,000. However, since there is a penalty multiplier of 1/the national readmission rate, the penalty is actually five times greater (1/.2 = 5) than the cost of the excess readmissions in a given DRG, or $100,000 in this example.

The penalty’s inverse relationship between the national readmission rate and the magnitude of penalty also may punish hospitals for making progress in reducing readmissions. Indeed, if the national readmission rate in the example above dropped from 20 percent to 10 percent, the penalty multiplier actually grows from 5 to 10. In the long run, the formula as currently constructed is unfair and counterproductive. This directly contradicts the goal of the program. In the coming year, the AHA will work with CMS and others to improve the measures used and to ensure the payment penalty is fair.

Hospital-acquired Condition (HAC) Payment Reduction Program. In the coming year, the AHA will work with CMS and others to improve the measures used, and to ensure the payment penalty is fair. The DRA requires CMS to identify HACs that are high cost or high volume or both; result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis; and could reasonably have been prevented through the application of evidence based guidelines. Since FY 2009, inpatient hospital discharges are not assigned to a higher paying DRG if a selected HAC is not coded as present on admission (POA). HAC measures are derived from Medicare claims, and

currently include foreign objects retained after surgery, air embolisms, blood incompatibility, pressure ulcers, vascular catheter-associated infections, catheter-associated urinary tract infections, falls and trauma, and glycemic control.

The ACA’s HAC payment reduction program goes one step further, applying a financial penalty to hospitals with high risk-adjusted rates of HACs in the DRA HAC policy, or any other quality measures selected by the Health & Human Services Secretary. Beginning in FY 2015, hospitals in the top quartile of national HAC rates will receive a 1 percent reduction to Medicare payments for all discharges. We expect to learn more about the program’s implementation in the coming year, including what specific quality measures may be used to determine payment penalties.

The AHA has concerns about the selection of quality measures in the ACA-mandated HAC payment reduction program, as well as the fairness of the payment penalty. As mandated by the ACA, the Measure Applications Partnership recently completed its yearly review of measures being considered for several federal quality reporting and payment programs. This process provides a preview of the measures that will be included in formal rules. Many of the same measures were proposed for both HAC and VBP. Using the same measures in more than one pay-for-performance program may subject hospitals to unfair double payment penalties. Moreover, the different constructs of the programs and the disparate ways in which good versus bad performance is identified could send potentially conflicting signals to patients and hospitals. Indeed, a hospital’s performance in one program could appear acceptable or even good, but in the other program may appear unacceptable or deserving of a payment penalty. To avoid such conflicting signals, it may be appropriate to consider giving heavier weight to a measure in one program, and removing it from the other.

The AHA also will discourage CMS from using the claims-based HAC measures currently in the DRA-mandated HAC program. These measures were considered for the VBP program and demonstrated poor reliability in a CMS-commissioned analysis. Moreover, many of the HACs, particularly retained foreign objects and air embolisms, occur very rarely. Hospitals may score in the top quartile, and be subjected to a payment penalty, if they have even one or two such events in a given year.
Improving Quality and Patient Safety

Background

In the past decade, hospitals have gone from working on quality and safety in small group efforts to publicly reporting quality and safety data, and engaging in large national projects as well as local efforts designed to improve care for patients. It began with 10 simple measures of care processes and was intended to grow over time to become a set of measures that provided an important window into the quality of care provided to hospital inpatients. The Centers for Medicare & Medicaid Services (CMS) currently requires the reporting of 54 measures for hospitals as part of the inpatient quality program and 22 as part of the outpatient quality reporting program. In addition, another set of 16 measures, chosen from a list of 29 candidate measures, are to be generated from the hospital’s electronic health record (EHR) and reported to CMS by any hospital seeking to be certified as a “meaningful user” of an EHR.

These data are displayed on the Hospital Compare website and used by the Department of Health and Human Services (HHS) in many of its payment programs for hospitals. However, these are not the only measures policymakers and payers are asking hospitals to collect and report. States, private payers and a variety of other organizations request data from hospitals and seek to rate and rank hospitals’ performance, as well as engage hospitals and their medical staffs in quality improvement efforts. While quality measurement and improvement are vital activities to which hospitals are dedicated, the deluge of activities and measures has become overwhelming.

AHA View

Hospitals began efforts to publicly provide quality information in order to share important and reliable quality information with the communities they serve, identify opportunities to improve care and be able to track their improvements. For some of the publicly reported measures, the improvement in care has been significant, as demonstrated in The Joint Commission’s Annual Report: Improving America’s Hospitals. For other measures, it has been more challenging to identify strategies that would lead to better performance as they do not provide the kind of reliable, compelling data that is needed. In other instances, different measures of the same aspect of care provide competing assessments of a hospital’s performance and create confusion for providers and the public.

The sheer volume of measures and disparate ranking and rating efforts has become overwhelming and distracting to quality improvement efforts, with different priorities, different goals and disparate incentives impeding efforts to enhance the coordination of care across the continuum. A strategically designed approach that promotes better health and better patient outcomes by appropriately involving all parts of the health care delivery system is urgently needed.

National Quality Strategy. The Patient Protection and Affordable Care Act (ACA) calls for developing a National Quality Strategy. The law directs HHS to create a strategic plan that identifies critically important areas for improvement,
sets goals and selects measures to be used in the federal programs. This plan relies on input from affected stakeholders, including hospitals, patients, purchasers, insurers and public policy experts.

The AHA strongly supports the premise of the National Quality Strategy. Our nation’s health care system can be improved by focusing on aspects of care that a broad array of stakeholders believe to be important. Alignment of quality reporting and payment across care settings and programs is critically important to the long-term success and sustainability of health care quality improvement efforts, and to helping patients and the general public find the information that is important, understandable and relevant to their care.

For the National Quality Strategy to be a success, it must align measures in various payment and public reporting programs using a consistent set of principles. At a time when health care resources are under intense scrutiny, the alignment of quality reporting and payment efforts across settings and programs would reduce the data collection burden and the unnecessary duplication of efforts among providers. Alignment also would help balance the allocation of limited resources between data collection and actual efforts to improve performance.

The AHA has actively participated in the efforts to convene affected stakeholders and provide input to HHS on priorities, goals and measures. The National Priorities Partnership advises the HHS secretary on priorities and goals, and the Measure Applications Partnership advises the secretary on the selection of measures for various programs. We continue to urge both bodies to take additional steps to more concretely enhance the alignment of quality measurement reporting and payment efforts.

**Linking Payment to Quality.** The AHA supports the general concept of linking hospital payment to meeting performance targets on quality measures. **However, we are very concerned that many of the quality measures upon which federal pay-for-performance programs are based do not produce accurate performance results, making them inappropriate to use for public reporting and accountability programs. Moreover, we believe the manner in which some of the payment penalties are calculated lack fairness and equity.** To ensure federal pay-for-performance programs realize their potential, the AHA’s efforts are focused on several fronts (refer to AHA issue paper, “Linking Payment to Quality,” for more details):

**Value-based Purchasing (VBP).** Mandated by the ACA, the VBP program pays hospitals for their actual performance on quality measures, rather than just the reporting of those measures, beginning in fiscal year (FY) 2013. The VBP program applies to inpatient prospective payment system (PPS) hospitals, with certain exceptions. It is budget neutral but is estimated to redistribute up to $963 million among hospitals in FY 2013.
While the AHA supported the general direction of CMS’s July 2011 hospital VBP proposed rule, the AHA expressed serious concerns about the inclusion of hospital-acquired conditions (HAC) in the VBP program when a separate HAC provision in the ACA also will impose financial penalties on a segment of hospitals beginning in FY 2015. We also were concerned that the inclusion of measures for 2014 had not been displayed on the Hospital Compare, as required by law.

CMS’s final rule did not resolve these issues. The AHA continued to raise objections with representatives from HHS and CMS emphasizing how some of CMS’s measures and initiatives conflicted with requirements in the ACA. The AHA was pleased that in the outpatient PPS final rule, published in November 2011, CMS suspended HAC measures for use in FY 2014.

In the FY 2014 regulation, the AHA expects to see CMS propose some additions to the slate of measures used to calculate hospitals’ VBP payments over the next several years. It also is possible CMS may propose to retire or suspend some measures that have already been adopted once performance on those measures has reached a level that suggests further improvement is unlikely. The AHA will continue to work with CMS to ensure that the measures selected for use in hospital VBP are evidence-based, reliable, valid and are important in improving patient outcomes and efficiency.

Post-acute VBP. The AHA is engaged in CMS’s processes to implement quality measures for inpatient rehabilitation facilities and long-term care hospitals, including the implementation of pay-for-reporting programs for both settings, which began in October 2012.

Readmissions. The ACA included a readmissions provision that imposes financial penalties on hospitals for “excess” readmissions when compared to “expected” levels of readmissions. This penalty program began Oct. 1, 2012 (FY 2013), with certain hospitals receiving a penalty of up to 1 percent of their Medicare payment. The payment penalty is based on the 30-day readmission measures for heart attack, heart failure and pneumonia.

The AHA had successfully advocated for a provision in the law stipulating that readmissions that are unrelated to the original reasons for admission or are planned should be excluded from the calculations of the measures. CMS did not address this requirement in the initial implementation of the penalty program. However, the agency did undertake a review of its readmission measures and has developed a substantial list of diagnoses that, when they are the cause for the readmission, will result in the readmission being excluded from the measures. Further work is needed to augment this list, and the AHA will continue to work with CMS to identify those reasons for readmission that should be excluded.
In addition, the AHA has adamantly advocated that CMS adjust the readmission measures to reflect socioeconomic differences in the patient populations served by different hospitals. Substantial research has shown that readmissions are the result of many factors; some are within a hospital’s control, and some are related to the lack of resources elsewhere in the community, such as adequate numbers of primary care clinicians; access to pharmacies, home health services and rehabilitation services; and access to healthy eating alternatives. There is compelling evidence that safety-net hospitals and others serving large numbers of low-income individuals will have difficulty reducing readmissions due to the lack of certain resources in the communities they serve. This creates an unfair system that puts safety-net hospitals at greater risk for substantial readmission penalties. Thus far, CMS has refused to account for these community-level factors in the readmission measures. The Medicare Payment Advisory Commission intends to further explore the role socioeconomic factors play in readmissions.

The AHA continues to urge CMS to account for planned and unrelated readmissions in the readmissions calculations in a manner that does not increase the reporting burden on hospitals, as well as to account for community-level factors that affect readmissions.

Hospital-acquired Conditions (HACs). The ACA’s HAC provision applies a financial penalty to hospitals with high risk-adjusted rates of the HACs identified by CMS for use in the inpatient PPS HACs policy, or any other condition selected by HHS. Beginning in FY 2015, hospitals in the top quartile of national HAC rates will receive a 1 percent reduction in their applicable Medicare payments for all discharges. HHS is required to develop and use a risk-adjustment methodology when calculating the HAC rates. The AHA strongly opposes this provision, as some hospitals will always experience financial penalties each year, despite overall progress made by the field in reducing the occurrence of these events. As mentioned above, we oppose CMS’s plans to include these same conditions in the VBP program, because both policies together could result in double penalties for certain hospitals.

Drug Availability and Safety. Hospitals and health systems remain deeply concerned about chronic drug shortages. There were 299 active drug shortages in the last quarter of 2012, the highest quarterly number to date. Nearly half of these shortages involve generic sterile injectable drugs, including critical hospital drugs such as succinylcholine, propophol, emergency syringes, preservative free morphine and electrolytes. Drug shortages continue in 2013 and make delivering patient care more difficult and dangerous by causing delays in treatment and forcing the use of alternative drugs that are less familiar to the provider. Shortages also are costly to hospitals and health systems in terms of staff time and other resources to manage the shortages and the increased cost of buying alternative drugs “off contract.”
The AHA has been working closely with the Food and Drug Administration (FDA) and Congress to better understand and seek solutions for this critical public health crisis. After strong advocacy by the AHA and a coalition of health care stakeholders, Congress passed the *Food and Drug Administration Safety and Innovation Act of 2012* (FDASIA), which included provisions to help alleviate critical drug shortages. The law:

- broadens and strengthens requirements for manufacturers to notify FDA in advance of discontinuance or interruptions in drug production;
- requires FDA to consider the impact on supply of drugs prior to taking enforcement actions against manufacturers;
- permits expedited drug application reviews and site inspections to help mitigate or prevent shortages;
- requires coordination between the FDA and the Drug Enforcement Administration for shortages involving controlled substances;
- relaxes FDA requirements for hospitals that repackage shortage drugs for use within their own health system; and
- requires FDA to establish a task force to develop and implement a strategic plan for enhancing the response to drug shortages and to submit an annual report to Congress on drug shortages and the agency’s related actions.

While the enactment of FDASIA was a significant achievement, additional efforts are underway. The AHA is engaged in an ongoing dialogue with FDA officials on the impact of shortages on hospitals and health systems and monitoring FDA’s implementation of drug shortage provisions of FDASIA. We also continue to work with House and Senate committees, the Government Accountability Office and other national stakeholder organizations to explore causes and solutions for drug shortages.

**Pharmacy Sterile Compounding.** Linked to drug shortages is the issue of inadequate federal and state oversight of pharmacy sterile compounding activities. As noted, some of the drugs in shortage are sterile injectable drugs critical for patient care in hospitals. While many hospitals have historically compounded drugs internally or contracted with outside compounding pharmacies, the chronic shortages of sterile injectable drugs has increased hospitals’ dependence on sterile compounding to meet patient needs. This increasing demand from hospitals and other providers has led some compounding pharmacies to expand to large-scale manufacturing.

Poor compounding practices and a lack of adequate oversight of compounding resulted in the tragic infections in 2012 from contaminated products made by the New England Compounding Center (NECC). Tens of thousands of patients were
exposed to nine contaminated lots of drugs compounded by NECC. As of December 2012, a total of 620 infections, which included 39 deaths, had been reported in 19 states.

The AHA is working to improve the safety of compounded medications and to preserve the ability of hospitals and health systems to compound drugs for their own patients. Throughout the NECC crisis, the AHA was in communication with FDA and the Centers for Disease Control and Prevention in order to keep hospital and health systems informed about the emerging crisis and its implications for patient care. In February, the AHA co-hosted with the Association of Health-System Pharmacists and the Pew Charitable Trust a Pharmacy Sterile Compounding Summit. The summit brought together national experts and stakeholders to examine the current processes and gaps in legislative and regulatory oversight with the goal of recommending solutions to improve patient safety. The AHA will continue to work with its members and national partners to develop a consensus around what steps are necessary to fill the gaps in oversight for compounding pharmacies and to pursue the enactment of legislative, regulatory and/or standards-based solutions to protect patients and ensure continued access to compounded medications.

**Conditions of Participation (CoP).** In February, CMS proposed changes to the Medicare CoPs for the second time since 1985. These changes are intended to reduce the burden on hospitals by eliminating outdated and outmoded requirements. For example, the agency rescinded a CoP provision that was finalized last year to require a member of the governing board of a hospital be a member of the medical staff and rather proposes to require periodic consultation between the governing body and the head of the medical staff. In addition, however, CMS proposed a new requirement that prohibits hospitals in the same health care system from having a unified medical staff serving two or more of its hospitals, if the hospitals have different CMS certification numbers. CMS also is working on revisions to the life safety codes embedded in the CoPs, and a proposed rule delineating those changes is expected later this year.

While the AHA applauds CMS for recognizing that its COPs are out of date, and while we support many of the proposed changes, we are concerned that CMS’s proposal to prohibit unified medical staffs runs counter to efforts to promote greater integration of health care providers to better care for patients. It also rejects the choices of the self-governing medical staffs and the hospital governing bodies at those facilities that have chosen to unify in order to promote improvement in care, greater efficiency and more standardization of practice in accordance with current science. The final rule is expected in the spring.
PURSUING EXCELLENCE

Through the AHA’s strategic platform to accelerate performance improvement, *Hospitals in Pursuit of Excellence* (HPOE), the AHA provides field-tested practices, tools, education and other resources that support hospital efforts to meet the Institute of Medicine’s Six Aims for Improvement – care that is safe, timely, effective, efficient, equitable and patient-centered. HPOE draws upon the resources of the entire association, including the American Organization of Nurse Executives, AHA Solutions, the Center for Healthcare Governance, Health Research & Educational Trust (HRET), Institute for Diversity in Health Management, Physician Leadership Forum and the AHA’s nine Personal Membership Groups.

CMS contracted with the AHA and HRET to be a driving force in the agency’s Partnership for Patients campaign. Through the Hospital Engagement Network contract, HRET assists hospitals with the adoption of best practices with the goal of reducing inpatient harm by 40 percent and readmissions by 20 percent. HRET provides education and training for the nearly 1,600 hospitals recruited by its 31 state hospital association partners in support of their quality improvement efforts in 10 targeted areas. The ongoing program has seen significant improvements in quality in areas such as infection control, early elective deliveries, falls, ventilator-associated pneumonia and readmissions, and has realized an estimated cost savings of more than $100 million.

In addition, by using the Comprehensive Unit-based Safety Program (CUSP), which is funded by the Agency for Healthcare Research and Quality (AHRQ) and led by HRET, hospitals have improved care in several ways:

- **On the CUSP: Stop CLABSI** – More than 1,000 hospitals and 1,800 hospital-unit teams participate in the project to reduce central line-associated bloodstream infections (CLABSI). The effort has reduced infections by 40 percent and is estimated to have saved more than 290 lives, and at a minimum $97 million in excess costs have been averted to date. HRET expects those figures to continue increasing over time.

- **Neonatal Intensive Care Units (NICUs)** – CLABSI also may affect infants. Frontline caregivers in 100 NICUs in nine states relied on the program’s prevention practice checklists and better communication to decrease CLABSI rates by 58 percent. During the course of the study, an estimated 131 infections were prevented with more than $2.2 million in cost savings.

- **On the CUSP: Stop CAUTI** – Reducing complications associated with catheter-associated urinary tract infections (CAUTI) results in decreased length of stay, patient discomfort, excess health care costs and sometimes mortality. With more than 1,200 hospitals in 29 states, the program continues to successfully expand to a wide variety of hospitals.
In addition to supporting this work, HRET continues to accelerate quality improvement in the health care field by:

- Sharing best practices through www.hpoe.org in the areas of patient safety, flow, wellness, care coordination, health information technology and other topics;
- Providing action guides on a variety of topics, including disparities, population health, variation and payment innovations; and
- Offering fellowship programs in patient safety and health care system reform.

**Achieving 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.

HRET is supporting the AHA’s work, which includes 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 allows hospitals to collect race, ethnicity and primary language data in a uniform way. The toolkit is continually reviewed to reflect ACA 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.
The Patient Protection and Affordable Care Act (ACA) will provide access to health care coverage to many Americans who previously were unable to afford it. Set to begin Jan. 1, 2014, the ACA’s main coverage improvements are based on three elements of health care reform – the individual mandate, expansion of Medicaid, and the creation of state and federal health insurance exchanges with financial subsidies for qualifying individuals. The Congressional Budget Office (CBO) originally projected that the ACA would extend coverage to 32 million uninsured people, or about 94 percent of legal residents. While the Supreme Court of the United States (SCOTUS) in 2012 upheld the constitutionality of the individual mandate, the court ruled that the federal government could not force states to expand their Medicaid programs or risk losing all of their Medicaid funding. It is now left to the states to decide whether to expand coverage through Medicaid. As a result, according to recent CBO projections, 5 million fewer people will get coverage through the ACA reforms – a drop to 27 million gaining coverage, or about 92 percent of legal residents. The undocumented, or non-legal, immigrant population residing in the U.S will remain uninsured for the foreseeable future.

The AHA believes that implementation of the ACA’s coverage provisions must occur in a thoughtful and transparent manner where the views of all stakeholders are considered. Yet, the administration has been “fast-tracking” rules and guidance to prepare for 2014. We continue to urge the administration to allow sufficient time for notice and public comment. Much of this guidance and rulemaking has granted a remarkable level of flexibility to state governments by allowing them to make their own decisions on major implementation questions. Since much of the implementation falls to state governments, the AHA continues to work closely with state hospital associations and hospitals to provide resources and tools to assist these state-level coverage discussions. The AHA will continue to monitor the ACA’s promise of coverage improvements as state governments decide whether they will expand their Medicaid program, and what role they will play in state-based or federally facilitated health insurance exchanges.

Ensuring that people enroll in the health insurance programs available to them is critical to achieving the increased coverage the ACA envisions. The AHA is a founding member of Enroll America, a collaborative organization working with partners that span the gamut of health coverage stakeholders – health insurers, hospitals, doctors, pharmaceutical companies, employers, consumer groups, faith-based organizations, civic organizations, and philanthropies – to engage many different voices in support of an easy, accessible and widely available enrollment process. Enroll America is focused on state-based enrollment initiatives, best practices and other tools to encourage enrollment through the health insurance exchanges and Medicaid. Visit www.enrollamerica.org to learn more.
Individual Mandate. The individual mandate requires that by Jan. 1, 2014, individuals, with some exceptions, secure the minimum essential health insurance coverage through either their employer, the state health insurance exchange or a public program, such as Medicaid, Medicare or the Children’s Health Insurance Program (CHIP), or pay a penalty. However, because the SCOTUS decision, in effect, gives states the choice to expand their Medicaid program, some low-income individuals may be left without coverage under Medicaid, particularly individuals with incomes below 100 percent of the federal poverty line (FPL) – the income threshold for coverage eligibility through the exchanges. The Internal Revenue Service recently announced that it will create an exception for individuals who are eligible for Medicaid but live in states that do not expand their Medicaid programs so these individuals are not subject to penalties for failing to secure coverage.

Medicaid. The ACA required that states expand Medicaid eligibility to all legal residents earning up to 133 percent of FPL (138 percent of FPL with a 5 percent income disregard), or about $15,282 for a single adult and $31,322 for a family of four. The federal government largely finances this expansion, by covering 100 percent of the cost of coverage for the first three years, phasing down to 90 percent in 2020 and beyond. By 2022, the Medicaid program is expected to add 12 million more enrollees as a result of the ACA expansion. This is 4 million fewer Medicaid beneficiaries than originally projected due to the SCOTUS decision. As of March 2013, 17 states and the District of Columbia have declared that they will expand their Medicaid programs with another eight states leaning in favor. Twelve states have declared they will not expand, another nine states are leaning against and the remaining four states are undecided.

Health Insurance Exchanges. Health insurance exchanges are central to coverage expansion and access. The exchanges are not insurance companies and do not offer insurance products that they develop and underwrite themselves. They are marketplaces through which, beginning in 2014, individuals (who do not have an offer of qualifying and affordable coverage from their employers) and small businesses may purchase coverage from private insurance companies. Individuals who purchase coverage through an insurance exchange may be eligible to receive federal subsidies that make the insurance more affordable. In addition, there are special temporary tax credits available to certain very small employers to provide coverage to their employees.

States have the flexibility to decide the nature of the exchanges in their state. The following chart outlines the three options for states: state-based exchange (SBE); state-federal partnership exchange (SPE); or federally facilitated exchange (FFE) run by the federal government. In each option, either the state or the federal government has the overall responsibility for operating the exchange, but each option allows certain tasks to be performed by either the state or the federal government.
As of March 2013, 17 states and the District of Columbia have declared their intention to create a state-based exchange, seven states have asked to form a partnership exchange, and the remaining states will have federally facilitated exchanges, at least initially (see chart below).

<table>
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<tr>
<th>Exchange Options for States</th>
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<tr>
<td><strong>Type of Exchange</strong></td>
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| State-based             | State                       | State may use federal government services for:  
|                         |                             | • Premium tax credit & cost sharing reduction  
|                         |                             | • Exemptions from tax penalties  
|                         |                             | • Risk adjustment program  
|                         |                             | • Reinsurance program  |
| State-Federal Partnership | Federal                     | State can accept responsibility for:  
|                         |                             | • Management  
|                         |                             | • Consumer assistance  |
| Federally Facilitated    | Federal                     | State may elect to operate:  
|                         |                             | • Reinsurance program  
|                         |                             | • Medicaid and CHIP eligibility determinations  |

As of March 2013, 17 states and the District of Columbia have declared their intention to create a state-based exchange, seven states have asked to form a partnership exchange, and the remaining states will have federally facilitated exchanges, at least initially (see chart below).

<table>
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<tr>
<th>Exchange Type</th>
<th>State</th>
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<tbody>
<tr>
<td>State-based</td>
<td>CA, CO, CT, DC, HI, ID, KY, MD, MA, MN, NV, NY, OR, RI, UT, VT, WA</td>
</tr>
<tr>
<td>State-Federal Partnership</td>
<td>AR, DE, IL, IA, MI, NH, WV</td>
</tr>
<tr>
<td>Federally Facilitated</td>
<td>AL, AK, AZ, FL, GA, IN, KS, LA, ME, MO, MS, MT, NE, NJ, NC, ND, OH, OK, PA, SC, SD, TN, TX, VA, WI, WY</td>
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Source: Kaiser Family Foundation, www.kff.org

Exchanges have to be ready to accept enrollees beginning Oct. 1, 2013 through March 31, 2014 (the initial open enrollment season), and be fully operational on Jan. 1, 2014. A number of rules have yet to be finalized, and one of the biggest open questions is exactly how will the FFEs operate.
**Qualified Health Plans (QHPs).** QHPs are the plans that will be sold within the exchanges. The 17 states and the District of Columbia that have moved ahead with establishing state-based exchanges are adopting a range of approaches to controlling how many QHPs will be offered to consumers through the exchange. The most liberal approach is that of a clearinghouse where all QHPs are allowed to participate; the most restrictive approach is for the exchange to be an active purchaser with the ability to limit the number and/or types of plans that can participate. Little is known, at this point, regarding how many QHPs will be in the SPE or the FFE.

**Essential Health Benefits (EHB).** The ACA requires that a set of EHB requirements be established against which health plans in the small group and individual markets can be compared. The EHB package must offer a robust set of benefits that cover 10 general categories. The levels of coverage are defined based on their actuarial equivalence to the benchmark: Bronze Level (60 percent), Silver Level (70 percent), Gold Level (80 percent) and Platinum Level (90). Federal regulations gave states the ability to set their own EHB benchmarks within certain federal parameters.

Beginning in 2014, some health plans must meet the EHB requirements depending on whether they hold “grandfathered” status and whether they are fully insured or self-insured. The AHA March 21 *Regulatory Advisory* describes how grandfathering works and which ACA provisions apply to which employers and when. It will be difficult for health plans to maintain grandfathered status over time, so that all health plans, ultimately, will have to meet the EHB requirements.

**Implications for Providers.** With the many moving parts involved in implementing the health insurance exchanges and the amount of flexibility granted to states, there are likely to be a variety of implications for providers in terms of both state regulations and actions taken by health plans in response. Examples include:

- **Changes in Health Plan Network Contracting.** Several health plan strategies are already taking shape, including adopting more narrow or tiered provider networks where in-network providers are separated into preferred and non-preferred tiers (often based on cost) with different cost-sharing for each tier and for non-network providers. Part of this strategy involves a greater focus on the application of quality metrics and elements of a value-based purchasing approach.

- **Changes in Health Plan Payment Methods for Providers.** To address affordability issues, some health plans are asking providers to accept Medicare-like payment rates or other types of rate reductions for plans offered through the insurance exchanges. Others, in response to the administrative cost limitations
of the medical loss ratio requirements, are moving more providers toward
capitated payment arrangements where certain administrative costs are
embedded in the delivery of care, thereby removing them from the health
plan. We also may see pressure on state governments to enact provider rate
review/setting requirements as plans address the premium rate review and
disclosure requirements of the ACA.

- **Administrative Simplification.** There are general administrative simplification
requirements in the ACA being implemented separately, but others are central
to the establishment and functioning of health insurance exchanges. Chief
among them is how Medicaid programs will interact with the exchanges,
especially on eligibility and enrollment processes. A more standardized and
coordinated process for helping uninsured patients achieve coverage will
reduce provider administrative and uncompensated care costs.

- **Covered Benefits.** The debate around the establishment of EHBs may have
both positive and negative effects for coverage of specific services, and under
what circumstances, depending on how individual states and the federal
government define EHB benchmarks and the issuers’ plan designs.
The national transition to more integrated and patient-centered health care increases the importance of health information technology (IT) systems that allow clinical information and decision support to be deployed and shared widely and efficiently. The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs provide incentives and penalties to encourage “meaningful use” of EHRs by hospitals and physicians.

The AHA successfully advocated for a more reasonable and flexible set of meaningful use requirements in Stage 1 of the program and a delay in the start of Stage 2 until fiscal year (FY) 2014. However, as hospitals invest capital and human resources to meet the meaningful use requirements, they are finding the regulations governing these programs to be challenging and complex and the price tag of EHRs and implementation high. The Centers for Medicare & Medicaid Services (CMS) administers the incentive programs, while the Office of the National Coordinator for Health IT (ONC) sets the rules for certifying EHRs. The certification rules affect hospitals and physicians because they determine the criteria providers’ IT systems must meet in order to qualify for incentive payments, and identify data standards that hospitals and physicians must use, such as vocabularies for recording health information and exchange standards for sharing information.

The AHA has been a longstanding advocate for health IT, specifically the rapid adoption of EHRs and national interoperability standards. Shared health information will allow clinicians and patients to have the information they need to promote health and make the most informed decisions about treatments. But this goal will be reached only if rules promoting IT adoption are clear and reflect the real-world practicalities of implementing new technology systems.

EHR INCENTIVE PROGRAMS
Congress intended the meaningful use incentives to be an important federal investment in harnessing the power of IT to enhance patient care. While hospitals have made great strides in implementing EHRs, in the first two years of the program, fewer than half of all hospitals and less than one-third of critical access hospitals (CAHs) received incentive payments for achieving meaningful use, according to data from CMS. Similarly, fewer than half of eligible physicians and other professionals have met meaningful use and received incentive payments. Nevertheless, the Department of Health and Human Services (HHS) is on track to raise the bar significantly in Stage 2 of meaningful use, and is currently developing additional requirements for Stage 3.

The AHA is concerned that the fast pace and broad scope of the program pose significant challenges to hospitals and physicians and has asked HHS to fund a thorough evaluation of experience to date before finalizing Stage 3 requirements.
We are pleased CMS heeded our concerns and will delay any rulemaking on Stage 3 until 2014; however, we believe additional time is necessary.

**Meaningful Use Stage 1.** CMS finalized confusing meaningful use rules, complicated by voluminous additional guidance, as well as a challenging operational structure. The AHA continues to work with CMS to clarify requirements and reduce the burden of registering and attesting to meaningful use. We have successfully advocated for changes to CMS policies that allow CAHs to include capital lease costs as allowed expenses under the program. In addition, CMS has responded to the AHA’s call to ensure that physicians providing services in outpatient departments of CAHs and billing under “Method 2” can qualify for incentives beginning in 2013. For more information, see the AHA issue paper “Small or Rural Hospitals.”

**Meaningful Use Stage 2.** CMS and ONC published final rules in September 2012 that increase the meaningful use requirements under Stage 2, particularly in the areas of sharing data with patients and other settings of care. The AHA successfully advocated for additional flexibility in Stage 2 by allowing providers some choice of which measures to meet and a shorter reporting period in FY 2014. Nevertheless, **we are concerned that the Stage 2 rules ask for too much, too soon, and we will carefully monitor the transition from Stage 1, with particular focus on clinical quality measures (CQMs) and the penalty phase.**

The AHA strongly supports the goal of using EHRs to streamline quality reporting while increasing access to real-time information to improve care. However, hospitals will not be able to routinely report CQMs through EHRs until measure developers and vendors build e-specifications and EHRs that support efficient generation of accurate and reliable quality data. CMS and ONC included infrastructure improvements in the Stage 2 meaningful use final rule intended to address several Stage 1 data capture and reporting challenges. However, the infrastructure remains problematic and significant work is needed to improve regulatory and technical processes. The AHA will work with CMS to identify and address issues with the electronic CQMs and better harmonize quality reporting requirements across programs. For more information, see the AHA issue paper “Quality and Patient Safety.”

The Stage 2 final rules also assess penalties for those who do not meet the meaningful use standards. By law, penalties begin in FY 2015; however, CMS will instead base penalties on whether hospitals met the meaningful use requirements two years earlier, or 15 months earlier for those attesting to meaningful use for the first time. The AHA strongly believes this unfairly accelerates the timeframe under which hospitals must meet meaningful use to avoid penalties.

Stage 2 also must be viewed in light of the many competing demands on hospital
and physician IT systems, including the movement to a new coding system for payment (ICD-10), new rules for electronic claims submission and other administrative transactions, the introduction of value-based purchasing, and additional health reform initiatives that will require calculation of quality metrics and other information system changes.

We are especially concerned about the impact of the EHR program incentives on small and rural providers. Data from the AHA’s surveys indicate that, while hospitals as a field saw increases in adoption of EHRs in 2011 and 2012, the rate of increase was highest among large and urban hospitals, and lowest among rural hospitals. In light of the variability in adoption by type of hospital, the AHA believes that Stage 2 of meaningful use should not start until at least 75 percent of hospitals and physicians have successfully achieved Stage 1.

Eligibility for Other Care Settings. The law establishing EHR incentive programs limited them to hospitals and physicians. As we move toward a more integrated health care system, additional settings of care also should receive support for transitioning to EHRs. We must ensure that all patients benefit from having their health information shared electronically across providers, including those receiving care in post-acute settings and rural health clinics.

Supporting Physician Adoption of EHRs. The limited exception to the Stark law and the anti-kickback law safe harbor that permit hospitals to assist physicians in developing EHRs will expire Dec. 31, 2013. These regulatory provisions should be extended beyond the current expiration date. The regulation also should include additional flexibility, such as allowing hospitals to share hardware or completely subsidize connectivity and software. For more information, refer to the AHA issue paper “Physicians and Non-Physician Practitioners.”

Health IT Safety. The increased use of EHRs has led to an increased focus on safety issues. It is a shared responsibility of health IT vendors, clinicians, health care organizations and federal agencies to ensure that health IT systems are designed, implemented and used to mitigate harm and promote safety. 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. The AHA supports the development of a voluntary code of conduct for EHR vendors with specific commitments to ensuring and promoting safety. The code of conduct should make clear that vendors are responsible for safe design and product development and will support safe use of their products. In addition, the code of conduct should discourage vendors from including in their contracts indemnity clauses or non-disclosure language that limit the ability of users to identify and raise safety concerns. The code of conduct also should address other areas, such as
transparency in pricing and adherence to existing coding conventions for systems that support billing.

OTHER INITIATIVES
In addition to advocating for EHR incentive programs that achieve their intended purpose, the AHA continues to work on the following health IT issues:

Health Information Exchange. ONC received $2 billion in stimulus funds to build the infrastructure to support interoperable health information exchanges (HIEs), but the capacity to share information remains limited. Each state received funds from HHS to establish a statewide HIE. The AHA supports HIEs and will work with state hospital associations to ensure that federal efforts do not unintentionally result in state-level systems that cannot be connected. Looking forward, the AHA also will work with federal partners to ensure that efforts to establish a nationwide health information network take into account how hospitals and physicians generate, use, share and secure health information.

ICD-10 Adoption. In 2009, HHS mandated adoption of new International Classification of Diseases (ICD) standards, or ICD-10. This replacement to the outdated ICD-9 coding system was long overdue, and the AHA supports the move to ICD-10 because it provides greater precision in the classification of disease. In 2012, HHS announced a one-year delay in ICD-10 implementation, until Oct. 1, 2014. The delay was prompted in part by problems implementing a new version of the Health Insurance Portability and Accountability Act’s (HIPAA) transaction standards that interrupted payments for some hospitals and physician offices, as well as by growing evidence that small providers were behind in the implementation process. The AHA supported this short, 12-month delay and recommended that HHS keep the transition for both diagnoses and procedures (ICD-10-CM and ICD-10-PCS) on the same timeline.

Unique Identifiers. The issue of how to match patients with their medical records remains unresolved despite the continued push for interoperability on a national scale. The AHA continues to press for a resolution and recommends the creation of a national unique identifier system to connect records and ensure that hospitals and physicians have the best information available when providing care for each patient. Such a system would facilitate efforts to increase the safety and quality of care given to patients.

Similarly, a system of unique identifiers for medical devices would increase efficiency and add an element of transparency to the medical device industry by providing basic, standardized information on all medical devices. The Food and Drug Administration finished a pilot test of a system for unique device identifiers for medical devices and is overdue to release proposed rules on the issue.
AHA continues to advocate for a uniform system of identification in order to streamline supply chain efficiencies, reduce costs and improve patient safety.

Operating Rules. The administrative simplification provisions of the Patient Protection and Affordable Care Act (ACA) call for the adoption of operating rules to improve the efficiency and effectiveness for each of the HIPAA transaction standards. The operating rules are intended to reduce variation in how individual health plans and clearinghouses actually implement the HIPAA transaction standards by adopting standardized best practices. The rules also seek to establish performance expectations on the electronic response to an inquiry in order to ensure a satisfactory response time. The ultimate goal of these new operating rules is to reduce administrative burden and cost for all parties.

CMS designated the Council for Affordable Quality Healthcare’s (CAQH) Committee on Operating Rules for Information Exchange (CORE) as the authoring body responsible for the advancement and creation of all of the operating rules. The AHA successfully advocated that CORE’s governance model be revised to include a balanced number of provider and health plan representatives to oversee the development of operating rules, as well as inclusion of other stakeholders.

At the AHA’s urging, the ACA included legislative language that requires health plans to file a statement with HHS certifying that their data and information systems are in compliance with the HIPAA standards and the corresponding operating rules starting Dec. 31, 2013. Failure to adhere to the operating rules will result in significant penalties on a health plan that is non-compliant. Key compliance dates for operating rules are as follows:

- Jan. 1, 2013 – Eligibility and claim status
- Dec. 31, 2013 – Health plans must certify their information systems are in compliance with the above operating rules
- Jan. 1, 2014 – Electronic funds transfer and electronic remittance advice
- July 1, 2014 – Adoption of other transaction operating rules
- Jan. 1, 2016 – Effective date for using operating rules for other transaction standards (such as claims or enrollment)

The AHA will continue to actively participate in the development of operating rules in collaboration with state and other national hospital associations. We encourage hospitals to join CORE to ensure that the hospital perspective is fully voiced.
**Hospital Price Transparency**

**Background**
Consumers deserve helpful information about the price of their hospital care, and the AHA is committed to providing it. Sharing meaningful information, however, is challenging because hospital care is specifically tailored to the needs of each patient. For example, a gall bladder operation for one patient may be relatively simple, but for another patient, it could be fraught with unforeseen complications, making meaningful “up front” pricing difficult and, perhaps, confusing for patients. Moreover, hospital prices do not include physician and other professionals’ costs or, most importantly, how much of the cost a patient’s insurance company may cover.

_The Patient Protection and Affordable Care Act (ACA)_ requires hospitals to report annually and make public a list of hospital charges for items and services, including Medicare-Severity Diagnosis-Related Groups (MS-DRGs). But more can, and should, be done to share health care information with the public, including, but not limited to, hospital pricing information.

**AHA Position**
Hospitals are a critical component to the fabric and future of our communities. We agree that consumers need useful information when making health care-related decisions for themselves and their families. Providing understandable and useful information about health care costs is just one way America’s hospitals are working to improve the health of their communities.

The AHA and its members stand ready to work with policymakers 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.

**AHA Principles for Price Transparency.** In 2006, the AHA Board of Trustees approved a policy regarding hospital pricing transparency. That policy calls 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:
• Expanding existing state transparency efforts – State governments, working with their state hospital associations, should expand existing efforts to make hospital charge information available to consumers. A 2013 AHA survey found that 35 states require hospitals to report information on hospital charges or payment rates and make that data available to the public; an additional eight states have voluntary efforts. These state efforts range from making public information about individual hospitals’ lists of prices (i.e., master charges), to pricing information on frequent hospital services, to information on all inpatient services.

• Health plan transparency – The ACA requires that health plans provide consumers with a summary of benefits and coverage, known as the Summary of Benefits and Coverage (SBC). Health plans also must provide a uniform glossary of terms commonly used in health insurance coverage, such as “deductible” and “co-payment,” written in plain language.

In addition, the new marketplace for the purchase of insurance in each state, known as the health insurance exchange will provide information to the enrollee about out-of-pocket costs based on what the essential health benefits health plans are required to include in their plan offerings. But plans can still substitute benefits as long as they are actuarially equivalent, generally meaning that a benefit can be substituted for another benefit as long as they have the same monetary value. So while these ACA consumer protections will provide basic information about what the health plan covers, they will not provide consumers with detailed information about what choices the health plan has made in substituting benefits while still meeting the “actuarial equivalent” standard. The resulting differences in what plans cover may continue to make plan comparisons difficult. In addition, the ACA consumer protections do little to standardize the information health plans provide consumers after care is given. The health plan explanation of benefits, or EOB, is largely left to the design of the health plan.

• Research on what consumers find useful – More research is needed to better understand what type of pricing information consumers want and would find useful in their health care decision-making. Consumers need different types of pricing information depending on whether and how they are insured. For example, a patient with traditional insurance that typically covers hospital services may want to know what the out-of-pocket costs would be for care at one hospital compared to another. Those with high-deductible health plans or health savings accounts also will need to know what their insurers require as out-of-pocket costs, as patients with high-deductible plans are responsible for the out-of-pocket costs of their initial care, up to their personal deductible.

For uninsured individuals of limited means, information should be provided directly by the hospital; the hospital, in turn, can determine whether a patient qualifies for state insurance programs, free or reduced cost care provided by the hospital, or other financial assistance (see below).
Consumer-friendly pricing language – Providers and insurers need to agree on consumer-friendly pricing “language” – common terms, definitions and explanations to help consumers better understand the information provided.

There are more than 1,300 private insurance companies, plus many more employers who self-insure for employees’ health care, in addition to public payers such as Medicare, Medicaid and the Department of Defense. Each of these payers offers a range of insurance products – types of health plans – and each product can have different combinations and permutations of covered and excluded services, patient cost-sharing, payment schemes and rules. Hospitals must comply with payers’ requirements for preauthorization and admission notification, as well as utilization review and reporting requirements.

Unfortunately, there is no standard set of requirements that hospitals must follow; each insurer can set its own requirements as well as change those requirements at any time without consultation with the hospitals that must comply with them. Further, as payers change patient cost-sharing arrangements – introducing high-deductible health plans, health savings accounts, multi-tiered coinsurance tied to provider rankings – hospitals are devoting more administrative resources to billing activities, making changes to their claims processing systems, and helping patients understand their coverage.

AHA-supported Legislation. The AHA supports state-based efforts regarding price transparency, including the Health Care Price Transparency Promotion Act of 2013 (H.R. 1326), 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-TX) and Gene Green (D-TX), the legislation also requires the Agency for Healthcare Research and Quality to study the types of health care cost information that consumers find useful, and ways it might best be distributed.

AHA Principles for Helping Patients with Payment for Hospital Care.
America’s hospitals are committed to doing everything possible to better serve patients and to treat them equitably, with dignity, compassion and respect from the bedside to the billing office.

In November 2003, the AHA Board of Trustees approved a Statement of Principles and Guidelines on practices hospitals should follow for patient billing and collection. The guidance was updated in May 2012 to reflect advancements in the field and changes made by the ACA applicable to tax-exempt hospitals. These guidelines reflect that commitment and demonstrate the shared partnership/responsibility between hospitals and patients to address billing issues in a timely, transparent and forthright manner.
America’s hospitals are united in providing care based on the following principles:

- **Communicating effectively with patients** – Hospitals should provide financial counseling to patients about their bills and should make the availability of such counseling widely known. Hospitals should respond promptly to patients’ questions about their bills and to requests for financial assistance. Hospitals should use a billing process that is clear, concise, correct and patient friendly. Hospitals should make available for review by the public specific information in a meaningful format about what they charge for items and services.

- **Helping patients qualify for financial assistance** – Under the ACA, non-profit hospitals must have a written financial assistance policy that includes eligibility criteria, the basis for calculating charges and the method for applying financial assistance. Hospitals should communicate this information to patients in a way that is easy to understand, culturally appropriate, and in the most prevalent languages used in their communities. Hospitals also should have understandable, written policies to help patients determine if they qualify for public assistance programs or hospital-based assistance programs. The ACA also requires that non-profit hospitals widely publicize (e.g., post on the premises and on the website and/or distribute directly to patients) these policies and share them with appropriate community health and human services agencies and other organizations that assist people in need.

- **Ensuring hospital policies are applied accurately and consistently** – Hospitals should ensure that all financial assistance policies are applied consistently and that staff members who work closely with patients (including those working in patient registration and admitting, financial assistance, customer service, billing and collections as well as nurses, social workers, hospital receptionists and others) are educated about hospital billing, financial assistance and collection policies and practices.

- **Making care more affordable for patients who qualify for financial assistance** – Hospitals should review all current charges and ensure that charges for services and procedures are reasonably related to both the cost of the service and to meeting all of the community’s health care needs, including providing the necessary subsidies to maintain essential public services. Under the ACA, non-profit hospitals also should have policies to limit charges for emergency and other medically necessary care for those who qualify for financial assistance to no more than the amounts generally billed to individuals who have insurance covering such care.

For more information, please visit:
**Background**

America’s hospitals have a long tradition of providing care for all who seek it. But that mission is threatened by an underfunded Medicare program. Recently, the Medicare Payment Advisory Commission (MedPAC) reported that Medicare payments continue to fall well below the cost of caring for America’s seniors. MedPAC estimates that aggregate Medicare hospital margins in fiscal year (FY) 2013 will be negative 6.0 percent.

At the same time, hospitals continue to face enormous changes associated with the *Patient Protection and Affordable Care Act of 2010* (ACA), as well as challenges and cost pressures related to growing uncompensated care, labor shortages, the adoption of electronic health records and the administrative burden of responding to requests from myriad Medicare contractors. Equally troubling, hospitals are grappling with a 2 percent automatic reduction in Medicare payments, which took effect April 1 as a result of the *Budget Control Act*’s sequester. Hospitals need adequate Medicare payment to ensure that patients and communities receive the care they expect and need.

**AHA View**

The sequester is the latest example of the federal government’s reliance on arbitrarily ratcheting down provider payments to address concerns about health care spending, the deficit and related budget issues. But, ratcheting provider payments will not put the nation on a sustainable path for the future; we need real reforms, not blunt cuts to providers. A new AHA report, “Ensuring a Healthier Tomorrow,” proposes targeted reforms that can improve the way we deliver care, slow the growth in health care spending and build a stronger foundation for the future. The report focuses on two interconnected strategies – promote and reward accountability, and use limited health dollars wisely. Each of the 12 recommendations has an associated list of suggested actions that providers, the government, insurers and employers, and patients can take to strengthen our health care system and our nation’s finances. Together, they provide a starting point for how – working together – all stakeholders can ensure a healthier tomorrow. The report is available at www.aha.org/healthiertomorrow.

**Inpatient PPS Rule.** The AHA anticipates that, in the FY 2014 inpatient prospective payment system (PPS) proposed rule, the Centers for Medicare & Medicaid Services (CMS) will continue to address alleged payment increases related to implementing the Medicare-severity diagnosis-related group (MS-DRG) system. Specifically, CMS believes that adoption of the MS-DRGs led to coding and classification changes that increased aggregate hospital payments without a corresponding increase in actual patient severity of illness. The AHA expects that in the FY 2014 inpatient PPS proposed rule (expected in late April), CMS will propose a temporary documentation and coding cut to comply with the *American Taxpayer Relief Act* (ATRA), which extends the period for which CMS must recoup alleged overpayments through FY 2012.
CMS must do so by making a temporary adjustment to the inpatient PPS over a four-year period. If CMS implements the cuts evenly over the four years, the reduction would be about 2.4 percent in FY 2014, and would remain in place through FY 2017. The reduction would then be restored in FY 2018. The agency also may re-propose the permanent documentation and coding cut of 0.8 percent that it withdrew in its FY 2013 inpatient PPS final rule due to our advocacy efforts. Nevertheless, the AHA continues to assert that CMS has used a flawed methodology and is overstating the effect of the documentation and coding change.

Disproportionate Share Hospital (DSH) Payments. The AHA also expects CMS to propose how it will implement changes to DSH payments, as mandated by the ACA. In FY 2014, the ACA begins reducing DSH payments to 25 percent of what hospitals would have received under the current formula. The basic elements of the Medicare DSH program – the designation criteria, the payment calculation methodology and the application of payment to the DRG – remain. Much of the savings generated by this change will then be used to supply a new pool of funds for Medicare DSH hospitals, with the size of the new DSH pool based on the decrease in the non-elderly uninsured population. Medicare DSH hospitals will receive additional payments from the new DSH pool based on their share of national uncompensated care for all Medicare DSH hospitals. The AHA will work to ensure that the modifications to the Medicare DSH program are made in accordance with the DSH principles adopted by the AHA Board of Trustees.

Patient Status. The AHA anticipates that CMS also will address the issue of patient status in its FY 2014 inpatient PPS rule. Whether a patient is admitted to a hospital as an inpatient or treated under outpatient observation status has implications for Medicare payment and Medicare beneficiary coverage. Traditionally, the decision to admit a patient as an inpatient has been up to the judgment of the treating physician, with oversight from the hospital and input from the patient. CMS recovery audit contractors and Medicare administrative contractors have started to second guess physician judgment, declaring that some patients who were admitted should not have been. The second-guessing has created ambiguity over who decides what constitutes an appropriate admission and what the criteria are for making such a determination.

In the calendar year (CY) 2013 hospital outpatient PPS rule, CMS requested feedback on potential policy options to address this issue, including:

- Establishing time-based admission policies, such as automatic inpatient admission after a patient has been receiving outpatient observation services for 24 or 48 hours;
- Adopting more specific clinical criteria and measures for inpatient admission;
• Using prior authorization for admissions where hospitals would know in advance that a service is approved and that the claim will be paid; and

• Exploring changes to payment policy to better align payment to the intensity of resources used in the care of patients.

In comments to CMS, the AHA described the advantages and disadvantages for each potential policy option but did not recommend one particular option. In its final CY 2013 outpatient PPS rule, CMS did not finalize an approach or reveal a preference among the policy options. We anticipate CMS will address the patient status issue in its FY 2014 inpatient PPS rule. When this occurs, the AHA will conduct further discussions with members to analyze the impact of CMS’s proposal for inclusion in our comment letter.

Area Wage Index. Hospitals repeatedly have expressed concern that the inpatient PPS area wage index is greatly flawed in many respects. Members of Congress and Medicare officials also have concerns with the present system. In response to these growing concerns, there has been a great deal of activity around the hospital wage index. In 2007, MedPAC developed an alternative wage index framework. In June 2011, the Institute of Medicine (IOM) issued a report containing recommendations for CMS on the wage index. In April 2012, CMS issued a congressionally mandated report on an alternative area wage index methodology. All of the proposals – MedPAC, IOM and CMS – would require legislative action for adoption.

In July 2011, the AHA Board of Trustees created a Medicare Area Wage Index Task Force to identify and evaluate the strengths and weaknesses of the current hospital wage index; develop a set of principles by which to evaluate various proposals to modify the hospital wage index, including review of AHA’s existing principles; evaluate proposals and studies to change the hospital wage index; and make recommendations to improve the accuracy, fairness and effectiveness of the hospital wage index.

The task force has engaged in an extensive amount of education, analysis and discussion about the wage index system. They identified five major issues that must be addressed to improve the wage index system: accuracy and consistency; volatility; circularity; reclassifications and exceptions; and labor markets. They agreed to nine principles and made seven recommendations to the AHA Board of Trustees to reform the wage index. The task force members agreed that it is unlikely that any set of recommendations would completely “fix” the wage index system for the hospital field. However, they felt very strongly that there are specific actions that would categorically improve the system for the field as a whole.

Self Referral to Physician-owned Hospitals. The ACA placed restrictions on physician self-referral to hospitals in which they have an ownership interest and limited expansion of those existing specialty hospitals that were grandfathered in
the law. The AHA strongly supports these restrictions and successfully pushed for their inclusion in the ACA. However, many physician-owned hospitals have pushed for repeal of these important restrictions. Since enactment, there have been several attempts to legislatively repeal or weaken the ACA by repealing new limits on physician referral to hospitals in which they have an ownership interest or eliminating the requirement that physicians disclose their ownership interest in hospitals to patients. These proposals were unsuccessful. The AHA opposes any legislation to repeal or weaken the ACA provisions and urges Congress to maintain the restrictions on physician self-referral that were included in the law.

**Direct Supervision of Hospital Outpatient Therapeutic Services.** In the CY 2009-2013 outpatient PPS rules, CMS mandated new requirements for “direct supervision” of outpatient therapeutic services. Direct supervision requires that a physician or a non-physician practitioner be immediately available to furnish assistance or direction throughout the performance of the procedure. Small, rural PPS hospitals and critical access hospitals (CAHs) have expressed concern that shortages of physician and non-physician practitioners in their communities make it difficult to comply with the direct supervision requirements. For CY 2013, as requested by the AHA, CMS again extended its policy not to enforce the direct supervision policy for therapeutic services provided in CAHs and rural hospitals with 100 or fewer beds. CMS expects this to be the final year of the enforcement moratorium and encourages hospitals to use the time to come into compliance with the supervision standard. CMS notes that the extension also will provide additional opportunities for stakeholders to bring their issues to the Advisory Panel on Hospital Outpatient Payment (HOP Panel) and for the panel to evaluate and provide recommendations on supervision of outpatient therapeutic services.

The HOP Panel is charged with assessing the appropriate supervision levels for individual hospital outpatient therapeutic services. As a result of the panel’s input, CMS in 2012 reduced the level of supervision for 49 outpatient therapeutic services. Two HOP Panel meetings are scheduled in 2013; one in March and one in late summer. However, no hospitals requested to make a supervision presentation to the HOP Panel at the March meeting. **Given the importance of this issue to the field, we strongly encourage hospitals to consult with their clinical staff and request an opportunity to testify before the HOP Panel’s summer meeting regarding additional services that could safely be downgraded to general supervision.** The AHA will issue a *Regulatory Action Alert* and other reminders when the summer meeting is announced.

Furthermore, while the AHA appreciates CMS’s efforts to make the requirements more flexible, we continue to be concerned that hospitals and CAHs will have difficulty implementing these requirements, and timely access to services will
The AHA continues to work with CMS and Congress to make more fundamental changes to the OPPS supervision policy. A workable solution would:

- Adopt a default standard of “general supervision” for outpatient therapeutic services and then apply reasonable exceptions to identify specific procedures that should be subject to 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.

Teaching Hospitals. 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 the value of the enhanced services beneficiaries receive in teaching hospitals, as well as its responsibility for funding its share of the direct and indirect costs of training medical professionals.

However, some policymakers are advocating for a significant reduction in Medicare graduate medical education (GME) payments to teaching hospitals. Specifically, the president’s 2011 Plan for Economic Growth and Deficit Reduction called for reducing the indirect medical education (IME) adjustment by 10 percent, from 5.5 percent to 5.0 percent, which would cut Medicare medical education payments by approximately $9 billion over 10 years. The Simpson-Bowles Deficit Reduction Commission recommended reducing the IME adjustment by 60 percent and limiting hospitals’ direct GME payments to 120 percent of the national average salary paid to residents in 2010. The Simpson-Bowles changes would reduce Medicare medical education payments by an estimated $60 billion through 2020. Recently, CMS reduced IME payments by $40 million in FY 2013 by including labor and delivery beds in the IME calculation.

With the help of strong advocacy from the field, Congress has not reduced Medicare direct or indirect medical education payments to teaching hospitals. The AHA will continue to oppose reductions in Medicare funding for IME and direct graduate medical education and also advocate for maintaining existing funding for graduate medical education conducted in children’s hospitals. For more information, see the AHA’s issue paper “Annual Appropriations.”

Given the current and projected shortage of physicians, especially in primary care and general surgery, the AHA continues to recommend 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. That’s why the AHA supports the Resident Physician Shortage Reduction Act of 2013 (S. 577/H.R. 1180), introduced by Sens. Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV), and by Rep. Joe Crowley (D-NY), respectively. The bill would increase the number of Medicare-supported physician training positions to at least 15,000 new resident positions, which is about a 15 percent increase in residency slots.

**Rural Hospitals.** Because of their small size, modest assets and financial reserves, and higher share of Medicare patients, rural hospitals disproportionately rely on government payments. While their Medicare margins have improved in recent years, more than 59 percent still lose money treating Medicare patients. The AHA is pleased that Congress provided relief on certain issues as part of ATRA. However, this law did not go nearly far enough in extending policies critical to rural hospitals. In 2013, we continue to work with Congress to provide small, rural hospitals with adequate reimbursement, including extension of rural provisions. For more information, see the AHA’s issue paper “Small or Rural Hospitals.”

**POST-ACUTE CARE**

**Long-term Care Hospitals (LTCH).** The AHA continues to advocate for more stringent patient and facility criteria for LTCHs in order to ensure that they have a distinct role in the continuum of care. The criteria proposal in the previously introduced Long-Term Care Hospital Improvement Act was refined in 2012 through further AHA member input and guidance. The AHA is urging action by Congress on this refined proposal. Our advocacy efforts include the critical goal of securing relief from CMS’s onerous and arbitrary “25% Rule.” Following a limited extension of 25% Rule relief, full implementation of the 25% Rule is scheduled to resume this summer. In addition, we continue to communicate with CMS and MedPAC on analyses demonstrating the unique and valuable role LTCHs have for beneficiaries with the highest levels of medical severity.

**Inpatient Rehabilitation Facilities (IRF).** IRFs provide a distinct clinical value to Medicare beneficiaries who need both intensive rehabilitation and hospital-level care. The uniqueness of IRFs is ensured by several policies, including the IRF “60% Rule” and stringent Medicare patient criteria that restrict IRF admissions to patients requiring hospital-level care including physician oversight. These policies have led to a flat curve for Medicare IRF payments and a dramatic drop in overall volume of IRF cases. IRFs also obtain extremely positive clinical outcomes, such as lower readmissions rates and higher discharges to community. Thus, the AHA will continue to oppose any proposals to raise the threshold of the IRF 60% Rule or to pay skilled-nursing rates for selected IRF cases. Access to IRF care must be ensured for beneficiaries who clinically require the unique combination of hospital-level care and intensive rehabilitation, such as brain injury, spinal cord injury and stroke patients.
Today, more than 69 million children, and poor, disabled and elderly individuals rely on the Medicaid program for their health care. By 2022, the Medicaid program is expected to add 12 million more enrollees as a result of the expansions included in the Patient Protection and Affordable Care Act (ACA). This is 4 million fewer Medicaid beneficiaries than originally projected by the Congressional Budget Office (CBO) due to the U.S. Supreme Court’s 2012 ruling that the federal government could not require states to expand their programs or risk losing all of their Medicaid funding.

Hospitals provide care to all patients who come through their emergency departments, regardless of ability to pay. But hospitals experience severe payment shortfalls when treating Medicaid patients. In 2011, on average, hospitals were paid 95 cents for every dollar spent treating Medicaid patients. In addition to this payment shortfall, hospitals in 2011 also shouldered the burden of providing $41.1 billion in care for the poor and uninsured for which no payment was received (uncompensated care). And while hospitals’ uncompensated care burdens should partially decline as insurance coverage – both public and private – expands, Medicaid payment shortfalls will persist.

Moreover, the sluggish economy has many governors and state legislatures considering additional Medicaid spending reductions to address looming deficits. Many governors also are seeking greater flexibility in managing their programs to rein in costs. In addition, the administration and some in Congress have proposed cuts to federal Medicaid spending. These include proposals to reduce spending on provider assessments, limit spending on durable medical equipment, implement fraud and abuse initiatives and convert the basic program to a block grant program.

To meet the challenges of the future, the Medicaid program must be transformed. But reducing provider payments and limiting states’ ability to finance their share of the Medicaid program, while adding burdensome oversight, are short-term budget savings tools that may impede change.

The AHA is pursuing the following key initiatives to protect hospitals:

**Coverage.** The ACA required that states expand Medicaid eligibility to all legal residents earning up to 133 percent of the federal poverty level (FPL) (138 percent of FPL with a 5 percent income disregard), or about $15,282 for a single adult and $31,322 for a family of four, with the federal government largely financing this expansion. CBO, shortly after the passage of the ACA, projected that up to 16 million people would receive coverage through the Medicaid program, or about half of the estimated 32 million individuals gaining health care coverage through the ACA. The Supreme Court’s decision, however, changed that trajectory.
by giving states the option to expand their Medicaid program. As a result, CBO’s coverage estimates fell to 12 million individuals who will receive their coverage through the Medicaid expansion. As of March 2013, 25 governors support expanding their Medicaid programs to take advantage of the federal government fully financing the first three years of coverage for the expansion population.

**Medicaid Disproportionate Share Hospital (DSH) Program.** The Medicaid DSH payment program provides supplemental payments to hospitals that serve a disproportionate number of low-income patients. The ACA reduces DSH payments, starting in 2014, to reflect the expected decrease in uncompensated care as reform increases the number of patients with health insurance. The reduction for fiscal year (FY) 2014 is $500 million. Since the ACA, Congress has passed two additional laws impacting Medicaid DSH. *The Middle Class Tax Relief and Job Creation Act of 2012* included reducing DSH allotments for FY 2021 for a savings of $4.1 billion over 10 years. And, *the American Taxpayer Relief Act of 2012* extended the ACA Medicaid DSH payment reductions through FY 2022 for a savings of $4.2 billion over 10 years.

CMS is expected to issue a proposed rule in spring 2013 outlining how to implement the DSH reductions. In distributing the DSH reduction, the secretary of Health and Human Services must give consideration to states based on three existing categories: High-DSH States; Low-DSH States; and 1115 Waiver Expansion States. The secretary also must take into consideration two factors: a state’s percentage of remaining uninsured; or whether a state targets DSH payments to hospitals serving a high volume of Medicaid inpatients and hospitals that have high levels of uncompensated care.

Working closely with the state hospital associations, the AHA has adopted principles for implementing the ACA’s Medicaid DSH payment provision. The AHA will urge CMS to implement the DSH reduction in a fair and equitable manner, consistent with our principles.

The reductions in Medicaid DSH payments required by the ACA and subsequent legislation were premised on a reduction in the number of uninsured patients as a result of coverage expansion. When the ACA was enacted into law, CBO projected that in 2014, the first year of DSH cuts, the number of uninsured would fall from about 51 million to 31 million. As of February 2013, CBO projects that 44 million will remain uninsured in 2014, a 42 percent increase compared to the 31 million estimated at time of enactment. **Given continued uncertainty regarding whether states will expand Medicaid, as well as questions about how the new exchange marketplace will work and how significant the decline in the uninsured will be,** the AHA is urging Congress to delay implementation of the Medicaid DSH reductions for three years, through 2017.
**Medicaid DSH Auditing Regulation.** In early 2012, CMS proposed changes to the Medicaid DSH reporting and auditing requirements that have governed the program since 2009. The AHA supports greater transparency and accountability in how the state Medicaid DSH programs function and believes the Medicaid DSH audit program could be a useful tool toward that end. However, the AHA has repeatedly expressed concern about CMS’s implementation of the audit program, particularly with respect to how unreimbursed costs are defined.

The AHA is pleased that in the proposed rule, CMS begins to address some of those concerns through changes in the definition of the uninsured and the clarification that all costs incurred in providing hospital services to Medicaid patients should be counted. In particular, the AHA strongly supports the agency’s proposal to allow unreimbursed costs for those individuals with minimal health care coverage in the determination of the hospital-specific DSH limit.

**The AHA continues to urge CMS to issue a final rule that includes further clarifications and modifications to the definition of uninsured and uncompensated care costs, specifically with respect to the unreimbursed cost of hospital-based physician services and unpaid high-deductible copayments.**

**Provider Assessment Program.** The Medicaid provider assessment program has allowed state governments to expand coverage, fill budget gaps and maintain access to health services by reducing proposed provider payment cuts. Despite its importance to financing state Medicaid programs, there have been recent proposals to scale back the use of provider assessments. The president’s FY 2013 budget would have cut $22.8 billion over 10 years by lowering the assessment rate cap from its current level of 6 percent to 3.5 percent in 2017 and beyond. Last year, House Republicans twice passed legislation that contained a reduction in the allowable assessment from 6 percent to 5.5 percent, which would result in $11.2 billion in cuts to the Medicaid program. Any loss of funding from provider assessments would put enormous pressure on already stretched state Medicaid budgets and could potentially jeopardize this critical safety-net program, just as states prepare to expand eligibility to comply with the ACA. The AHA strongly urges Congress not to restrict the use of provider assessments by the states.

**340B Drug Discount Program.** Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to taxpayer-supported health care facilities that care for uninsured and low-income people. Covered entities include community health centers, children’s hospitals, hemophilia treatment centers, and public and nonprofit disproportionate share hospitals that serve low-income and indigent populations. Safety-net and rural hospitals act as the health care safety net for their communities and depend on the 340B drug discount program to provide pharmacy services to their most vulnerable patients. The 340B program allows these hospitals to stretch their limited resources.
Currently, the program is available only for outpatient services provided at these hospitals – it is not available for pharmacy services provided to inpatients who often have poor financial health. While the AHA is pleased that, under the ACA, Congress expanded eligibility for the discount drug prices available under the program to critical access hospitals (CAHs), certain sole community hospitals (SCHs) and rural referral centers (RRCs) for outpatient services, the ACA expansion did not go far enough. In addition, expanding the program would relieve 340B hospitals from the burden of carrying two separate pharmaceutical inventories and pricing structures for inpatient and outpatient drugs.

The expansion of the program also is good for taxpayers. Expanding the 340B program would generate savings for the Medicaid program by requiring hospitals to rebate Medicaid a percentage of their savings on inpatient drugs administered to Medicaid patients. This change also would reduce Medicare costs, as CAHs are paid 101 percent of their inpatient and outpatient costs by Medicare, and the 340B pricing mechanism will lower CAHs’ drug costs. According to CBO, expanding the program to cover inpatient services would save the federal government upwards of $1.2 billion.

The AHA supports extending the 340B discounts to the purchases of drugs used during inpatient hospital stays and opposes any attempts to scale back this vital program. In addition, while AHA supports 340B program integrity efforts to make sure that covered entities comply with the program requirements, we urge the Health Resources and Services Administration (the agency with oversight of the 340B program) to work with hospitals on any compliance issues identified.
Background

Approximately 51 million Americans live in rural areas and depend upon the hospital as an important, and often the only, source of care in their community. Remote geographic location, small size and limited workforce along with physician shortages and often constrained financial resources pose a unique set of challenges for rural hospitals. Compounding these challenges, rural hospitals’ patient mix makes them more reliant on public programs and, thus, particularly vulnerable to Medicare and Medicaid payment cuts. For more than half of rural hospitals, Medicare does not cover the costs of caring for Medicare patients.

Equally troubling are several proposals released by the Obama administration that would put rural hospitals at risk of cuts in several areas. For example, the president’s fiscal year (FY) 2013 budget outline sought to reduce critical access hospital (CAH) payments from 101 percent to 100 percent of reasonable costs. In addition, the administration proposed to eliminate in FY 2014 the CAH designation for hospitals that are less than 10 miles from the nearest hospital. Together, the administration estimates these rural proposals would save approximately $2 billion over 10 years.

AHA View

The AHA is working to ensure that all hospitals have the resources that they need to provide high-quality care and meet the needs of their communities. We are advocating for appropriate Medicare payments, extending expiring beneficial Medicare provisions, improving federal programs to account for special circumstances in rural communities, and seeking adequate funding for annually appropriated rural health programs. In addition, existing special rural payment programs – the CAH, sole community hospital (SCH), Medicare-dependent hospital (MDH) and rural referral center (RRC) programs – need to be protected and updated.

Rural Legislation. The American Taxpayer Relief Act of 2012 contained many provisions important to rural hospitals and beneficiaries, including extending the following provisions that had expired:

- Low-volume hospital payment adjustment (now expires Sept. 30);
- Medicare-dependent hospital program (now expires Sept. 30);
- Ambulance add-on payments (now expires Dec. 31); and
- Outpatient therapy caps exception process (now expires Dec. 31). (While the AHA supports extending the outpatient therapy exceptions process, we oppose the temporary expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.)

The AHA is working to extend beyond 2013 the law’s aforementioned rural extender provisions, in addition to several others. We also will advocate before Congress for these critical programs and provisions:
• Medicare reasonable cost payments for certain clinical diagnostic laboratory tests for patients in certain rural areas (expired June 30, 2012);

• Direct billing for the technical component of certain physician pathology services (expired June 30, 2012);

• Outpatient hold harmless payments (expired Dec. 31, 2012, although for SCHs with more than 100 beds, it expired March 1, 2012);

• Allow hospitals to claim the full cost of provider taxes as allowable costs;

• Ensure CAHs are paid at least 101 percent of costs by Medicare Advantage plans;

• Ensure that the Centers for Medicare & Medicaid Services (CMS) appropriately addresses the issue of direct supervision for outpatient therapeutic services for rural hospitals and CAHs;

• Ensure rural hospitals and CAHs have adequate reimbursement for certified registered nurse anesthetist services, including stand-by services;

• Exempt CAHs from the Independent Payment Advisory Board;

• Provide small, rural hospitals with cost-based reimbursement for outpatient laboratory services and ambulance services;

• Provide CAHs with bed size flexibility;

• Reinstate CAH necessary provider status;

• Remove unreasonable restrictions on CAHs’ ability to rebuild; and

• Extend the 340B drug discount program to additional hospitals and for the purchases of drugs used during inpatient hospital stays for all eligible hospitals, and oppose any attempts to scale back this vital program.

OTHER CONCERNS

Direct Supervision. For the past several years, CMS has modified its policies related to the agency’s “direct supervision” requirement of outpatient therapeutic services. For 2013, at the AHA’s urging, CMS adopted several positive changes to the regulations, including a delayed enforcement of the direct supervision policy through 2013 for CAHs and small and rural hospitals with fewer than 100 beds. For more information, see the AHA’s “Medicare” issue paper.

Electronic Health Records (EHRs) and Meaningful Use. CMS has established confusing meaningful use rules complicated by voluminous additional guidance, as well as a challenging operational structure. The final Stage 2 rules raise the bar even higher. For hospitals paid under the Medicare prospective payment system, CMS will assess penalties beginning in FY 2015 based on whether a hospital met meaningful use in an earlier time period. For CAHs, the penalties will be based on same-year performance.
The AHA continues to work with CMS to clarify requirements and reduce the burden of registering and attesting to meaningful use. We are pleased that CMS has announced a reversal of its policy and will now allow CAHs to include capital leases as allowable costs in determining their meaningful use incentive payment. We also are pleased that CMS has determined that physicians who provide services in the outpatient departments of CAHs and for whom bills are submitted via the optional, or “Method 2,” billing approach are now eligible to participate in the Medicare EHR Incentive Program. Finally, CMS also will allow providers additional time in 2014 to upgrade their EHRs and transition to Stage 2.

However, we continue to be concerned about the impact of the program on small and rural providers, and believe that the EHR incentives program should close, not widen, the existing digital divide. To date, only a small share of hospitals have met the meaningful use requirements for Stage 1 – fewer than half of all hospitals, and less than one-third of CAHs. Only CAHs that successfully attested to meaningful use in FY 2011 or FY 2012 will benefit fully from the incentives; the vast majority will qualify later and receive incentives for fewer years.
Background

The Patient Protection and Affordable Care Act (ACA) provides strong incentives to increase collaboration between hospitals and physicians to deliver high-quality, efficient care. Success in value-based purchasing, reducing readmissions and managing costs within a bundle or per capita rate requires making physicians full partners in examining and redesigning care processes. In 2011, America’s community hospitals employed approximately 226,000 physicians, including interns and residents, and that number is growing rapidly. Strong leadership teams and hospital-physician partnerships are needed to guide the complex changes coming as a result of health reform. As such, the AHA has identified several physician issues that affect hospitals.

AHA View

Physician Payment. The Medicare physician payment formula is severely flawed and would have resulted in significant payment cuts to physicians in 2013 without legislative action. In December 2012, Congress passed the American Taxpayer Relief Act (ATRA), which prevented a 26.5 percent cut to Medicare physician payments that was scheduled to take effect Jan. 1, and provided physicians with a zero percent update for the remainder of the year. The cost of this payment fix was $25 billion. Unfortunately, this fix, along with other provisions, was funded in part by an $11 billion documentation and coding reduction to hospital inpatient payments. **While averting a cut in payments to physicians was essential, it should not have been financed by reducing payments to hospitals.** We will continue to work with Congress to find a permanent solution to the Medicare physician payment problem, while strongly opposing additional cuts that could be harmful to hospitals’ ability to fulfill their mission of caring.

Direct Supervision. In the calendar year (CY) 2009-2013 outpatient prospective payment system (PPS) rules, the Centers for Medicare & Medicaid Services (CMS) mandated new requirements for “direct supervision” of outpatient therapeutic services. Direct supervision requires that a physician or a non-physician practitioner (NPP) be immediately available to furnish assistance or direction throughout the performance of a procedure. Small, rural PPS hospitals and critical access hospitals (CAHs) have expressed concern that shortages of physician and NPPs in their communities make it difficult to comply with the direct supervision requirements. For CY 2013, as requested by the AHA, CMS again extended its policy not to enforce the direct supervision policy for therapeutic services provided in CAHs and rural hospitals with 100 or fewer beds. CMS expects this to be the final year of the enforcement moratorium and encourages hospitals to use the time to come into compliance with the supervision standard. CMS notes that the extension also will provide additional opportunities for stakeholders to bring their issues to the Advisory Panel on Hospital Outpatient Payment (HOP Panel) and for the panel to evaluate and provide recommendations on supervision of outpatient therapeutic services.
The HOP Panel is charged with assessing the appropriate supervision levels for individual hospital outpatient therapeutic services. As a result of the panel’s input, CMS in 2012 reduced the level of supervision for 49 outpatient therapeutic services.

While the AHA appreciates CMS’s efforts to make the requirements more flexible, we continue to be concerned that hospitals and CAHs will have difficulty implementing these requirements, and timely access to services will be reduced. The AHA continues to work with CMS and Congress to make more fundamental changes to the outpatient PPS supervision policy. A workable solution would:

- Adopt a default standard of “general supervision” for outpatient therapeutic services and then apply reasonable exceptions to identify specific procedures that should be subject to 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.

Physician Quality Reporting. The ACA extended the voluntary Physician Quality Reporting System (PQRS) program through 2014. The program provides an incentive payment to physicians, eligible professionals (EPs) and group practices that satisfactorily report data on certain quality measures under the physician fee schedule (PFS). In 2011, more than 280,000 EPs participated individually in the PQRS, and CMS paid more than $261 million in incentive payments. For 2013, successful participants can earn an incentive payment of 0.5 percent of their total PFS charges. Beginning in 2015, the ACA implements a mandatory physician quality reporting program, where EPs will be penalized 1.5 percent of their payments if they fail to successfully report quality measures. The 2015 penalty will be based on 2013 reporting. This penalty increases to 2.0 percent in 2016 and beyond. CMS estimates that approximately 20 percent of EPs are successfully reporting quality data. The AHA is committed to partnering with physicians, eligible professionals and others to ensure that hospital and physician quality measures are harmonized and support high-quality, efficient care across the continuum of care.

eRx Incentive Program. Congress in 2009 adopted the Electronic Prescribing (eRx) Incentive Program for physicians and other EPs to promote the adoption and use of electronic prescribing. The eRx incentive program is separate from, and in addition to, the PQRS. For 2013, EPs who are successful electronic prescribers may receive an incentive bonus of 0.5 percent. Those providers who do not participate will receive a 1.5 percent payment penalty.
In 2011, CMS paid 282,000 EPs more than $285 million in eRx payments, and another 136,000 EPs were subject to the 2012 eRx payment penalty because they either did not meet the eRx reporting requirements in the first half of 2011, did not meet exclusion criteria for the adjustment, or did not otherwise qualify for an exemption. **Last year, at the AHA’s urging, CMS adopted additional hardship exemption categories and extended the deadline for EPs to request an exemption. We will continue to urge CMS to base the 2013 payment penalty on a full year of CY 2013 data (rather than data from the first six months of CY 2013) to allow more EPs to satisfactorily meet the program requirements.**

**Electronic Health Records.** In 2009, Congress passed the *American Recovery and Reinvestment Act*, which included $19.2 billion in funds to increase the use of electronic health records (EHRs) by physicians and hospitals. While the physician community is moving forward with adoption of EHRs, like hospitals, they have encountered a number of challenges due to complicated and confusing regulations. At the end of 2012, the second year of the program, only 106,000 eligible physicians and other professionals received incentive payments for achieving “meaningful use” of EHRs. Nevertheless, the Department of Health and Human Services is on track to raise the bar significantly in Stage 2 of meaningful use. The AHA is concerned that the Stage 2 rules asks for too much, too soon, and we will carefully monitor the transition from Stage 1, with particular focus on clinical quality measures and EHR payment penalties that begin in fiscal year 2015. (Refer to the AHA issue paper, “Health Information Technology,” for more information.)

The PQRS, eRx and EHR incentive programs present overlapping and often conflicting reporting requirements for EPs who may be eligible for incentive payments or subject to penalties. While the number of EPs who have adopted these programs has increased significantly over the past year, the total number of EPs participating remains low. Physicians and EPs have a number of competing demands related to their information technology systems, new rules for electronic claims submission and other administrative transactions (5010), movement to a new coding system for payment (ICD-10), and the introduction of other health reform initiatives. **The AHA will encourage CMS to adopt reasonable implementation timeframes and remove the overlap in reporting requirements to minimize the administrative burden on physicians and encourage their reporting of quality measures and use of health information technology.**

In addition, the limited exception to the Stark law and anti-kickback law safe harbor that permit hospitals to assist physicians in developing EHRs will expire Dec. 31, 2013. **The AHA will urge policymakers to extend these regulatory provisions beyond the current expiration date. In addition, the regulation should include greater flexibility, such as allowing hospitals to share hardware or completely subsidize connectivity and software.**
Physician Leadership Forum. An essential element to transform America’s health care is a strong collaborative relationship between hospitals and physicians. To foster that collaboration, the AHA launched the Physician Leadership Forum (PLF) in 2011 as a new way for physicians and hospitals to advance excellence in patient care. Through the PLF, the AHA works closely with the medical community to identify best practices to deliver value-based care and disseminate them through educational offerings and resources. In addition, in 2013, the AHA added a Committee on Clinical Leadership to its governance and policy groups to offer physicians a unique opportunity to participate in the AHA policy and advocacy development process. To learn more, visit www.ahaphysicianforum.org.
Each year, Congress considers a dozen appropriations measures that fund various discretionary programs, such as health care (excluding Medicare and Medicaid), national defense and education, as well as general government operations like the administration of federal agencies. The appropriations bill that funds the departments of Labor, Health and Human Services (HHS) and Education is particularly important for hospitals because it funds a variety of programs affecting the health care field.

Congress failed to pass any individual appropriations bills for fiscal year (FY) 2013. Instead, lawmakers passed large omnibus bills or continuing resolutions (CRs) to fund government programs. For example, in late September 2012, Congress passed a CR to fund the government until March 27 at FY 2012 levels. Just prior to that March deadline, Congress approved another CR for the remainder of FY 2013. That CR encompasses the Budget Control Act’s sequester reductions.

For FY 2014, the House and Senate each have passed a budget resolution. These budget resolutions along with the president’s budget, which was released in mid-April, set a framework for spending, taxation and other fiscal items in the coming fiscal year. They are not appropriations bills, which actually allocate money for specific purposes. If the budget resolutions differ – as the FY 2014 plans do – the House and Senate are supposed to hammer out a compromise before beginning work on appropriations. That seems unlikely this year; thus, each chamber of Congress may continue to rely on its own budget resolutions to fund most federal programs for FY 2014.

The AHA will urge lawmakers to craft and approve a FY 2014 appropriations bill for the departments of Labor, HHS and Education that bolsters the health care workforce, funds biomedical research, improves access to care for vulnerable Americans, enhances hospitals’ disaster readiness and supports efforts to improve hospital quality-improvement research.

Children’s Hospitals GME. The Children’s Hospitals Graduate Medical Education (CHGME) program funds independent children’s teaching hospitals to support the training of pediatric and other medical residents in GME programs. Funding under the program is critical to ensuring an adequate supply of physicians trained to care for children. In addition to training the next generation of pediatricians and pediatric sub-specialists, these hospitals care for many of our nation’s medically vulnerable children. Currently, independent children’s hospitals train more than 40 percent of general pediatricians, 43 percent of all pediatric specialists and the majority of pediatric researchers.

The AHA supports reauthorization of the CHGME program and urges funding of at least $265 million for FY 2014. We oppose efforts to reduce funding for this program.
Reductions to CHGME from the current level will be detrimental to the mutual goals of strengthening the primary care workforce and ensuring timely access to critical, high-quality specialty care.

**Health Professions Education and Workforce Challenges.** As our nation moves toward transforming our health care system, we need to make a substantial investment in building a strong workforce to ensure access to health care services for all. The AHA supports the maximum funding level possible for the following Health Resources and Services Administration (HRSA) discretionary programs that seek to address workforce challenges:

**Nursing Workforce Development.** While the recession temporarily eased workforce vacancies in some areas, as the economy improves, shortages will return. The demand for registered nurses and other health care personnel will continue to rise as the “baby boomers” begin to retire and as expanded coverage increases the demand for care. HHS estimates that by 2020, our nation will need 2.8 million nurses – at least 1 million more than the projected supply. In addition, the Bureau of Labor Statistics projects severe shortages in many allied health professions. We must have adequate funding to maintain a vibrant workforce and bolster the educational pipeline.

**Health Professions Programs.** An adequate, diverse and well-distributed supply of health care professionals, including allied health care workers, is indispensable to our nation’s health care infrastructure. Health professions programs help address problems associated with maintaining primary care providers in rural areas. These programs also support recruitment of individuals into allied health professions. Without decisive intervention, workforce shortages threaten hospitals’ ability to care for patients and communities.

**National Health Service Corps (NHSC).** The NHSC awards scholarships to health professions students and assists graduates of health professions programs with loan repayment in return for an obligation to provide health care services in underserved rural and urban areas.

**Training for Diverse Health Professionals.** The AHA urges Congress to fund the Centers for Excellence and the Health Careers Opportunity programs, which focus on recruiting and retaining minorities in the health professions to build a more diverse health care workforce that reflects our patients and communities.

For more information, see the AHA issue paper, “Workforce.”

**Rural Health Programs.** Rural health programs such as the Medicare Rural Hospital Flexibility Grant Program, Rural Health Outreach and Network Development, State Offices of Rural Health, Rural Telehealth, Rural Policy
Development and other health care programs are vital to ensuring that needed services remain available in America’s rural communities. The AHA urges Congress to reject efforts to cut funding below current levels for these programs. (For more information, see the AHA issue paper, “Small or Rural Hospitals.”)

Disaster/Emergency Preparedness. Hospitals play a key role in the nation’s emergency preparedness and response as part of America’s health care infrastructure. In times of disaster, such as in the wake of Hurricane Sandy, communities look to hospitals not only to mobilize resources to care for the ill and injured but also to provide food and shelter, and coordinate relief and recovery efforts. As part of this standby role to communities, hospitals are pivotal to disaster-response activities, whether they are rural, critical access hospitals or Level 1 trauma centers.

The Hospital Preparedness Program (HPP) is the primary grant program for hospital emergency preparedness. It has provided funding to enhance hospital preparedness and response for the past 11 years and is critical to hospitals’ ability to continue to be prepared. While the recently passed Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 addresses our national medical and public health preparedness and response capabilities, the AHA is disappointed that the bill reauthorizes funding at $375 million per year, a level that is nearly $100 million dollars less than the amount authorized in the 2006 Pandemic and All-Hazards Preparedness Act. Furthermore, the annual appropriations for the HPP have declined nearly 30 percent since the program began in FY 2003. Cuts of this magnitude undermine preparedness and diminish the ability of the nation’s hospitals to respond in the event of a large-scale disaster.

In addition, the AHA urges sufficient funding to support an increase in production capacity for vaccines and antiviral agents, the stockpiling of supplies needed in a pandemic, such as ventilators and personal protective equipment, and the development of rapid diagnostic tests and enhanced surveillance.

The AHA will continue to work with Congress and the Obama administration to ensure that funding earmarked for hospital preparedness is sustained. (For more information, see the AHA issue paper, “Hospital Emergency Preparedness and Response.”)

Quality and Comparative Effectiveness. The AHA supports continued research to identify strategies for improving the quality and safety of health care. Much of this research is funded by the Agency for Healthcare Research and Quality (AHRQ). But the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) also play important roles.

Previous research projects have, for example, identified effective strategies for reducing several types of hospital-acquired conditions and helped to develop and
disseminate the tools that enable all hospitals to routinely use those strategies. The result has been a nationwide improvement in patient safety, driving down the number of central line-associated blood stream infections and catheter-associated urinary tract infections. While this federal investment in research is important and successful, there remain many important opportunities to improve patient safety and enhance the overall quality of patient care. The AHA supports increased funding for AHRQ and continued support for CMS’s Innovation Center and the CDC so they can continue to fund the development of vital knowledge to improve the delivery of safe and effective care.

National Institutes of Health (NIH). The NIH is our nation’s leading biomedical research agency supporting vital scientific projects that have led to breakthroughs in disease treatment, cures for diseases and innovative treatments to ease human suffering. The 27 institutes of the NIH drive scientific innovation, and they develop new and better diagnostics, preventive strategies to avoid chronic illnesses, and more effective treatments for a wide variety of diseases. The sequester has resulted in a cut of more than 5.1 percent to the NIH, which will stymie important research projects. The AHA supports increased investment in the NIH and a restoration of funding cut by the sequester.

Other Health Care Programs. Hospitals play an important role in coordinating efforts to improve the public’s health. Federal funding should reflect both the hospital commitment to and the challenge of preventing and managing chronic conditions, dealing with life-threatening injuries and improving access to care for underserved residents. The AHA urges Congress to increase funding for the Maternal and Child Health Block Grant, Healthy Start, Ryan White HIV/AIDS Program, Emergency Medical Services for Children and the Substance Abuse and Mental Health Services Administration.
Background

The Patient Protection and Affordable Care Act (ACA) greatly increases the demand for caregivers, especially primary care physicians and nurses. The law will extend coverage to approximately 27 million 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 identifies several initiatives to increase the supply of health care workers. For example, the law provides flexible loan repayment programs for caregivers to increase the workforce pipeline of primary care physicians, nurses and allied health professionals.

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 an invaluable resource in every community. As hospitals’ national advocate, the AHA addresses workforce issues on several fronts – workforce shortages, employee relations and employee wellness.

Workforce Shortages. Adequate numbers of competent and well-trained nurses, physicians and allied 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:

- Identify how to create the workforce necessary to meet the primary care needs of patients in a community’s delivery system. The AHA is examining how the scope of practice for health care providers can be addressed to provide greater access to care to meet the ACA-related increased demand for primary care services. In January, the AHA released a white paper titled, “Workforce Roles in a Redesigned Primary Care Model,” that makes recommendations for redefining the health care workforce to be better able to provide primary care services.

- Define principles to address the roles of the direct care providers of the future. The AHA assembled a roundtable to explore the roles of the bedside care team and multi-disciplinary teams in providing high-quality health care. A white paper with their recommendations will be published this spring.

To help hospitals sustain, grow and enhance the health care workforce, the AHA together with its affiliates, the American Organization of Nurse Executives

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1 As a result of the 2012 U.S. Supreme Court ruling on the ACA that the federal government could not force states to expand their Medicaid programs, the Congressional Budget Office now estimates that the ACA will extend coverage to 27 million uninsured individuals. This is 5 million fewer people than originally projected when the ACA was passed.
(AONE) and the American Society of Healthcare Human Resources Administration (ASHHRA), launched the AHA Workforce Center, www.healthcareworkforce.org, an online hub. The center brings together resources and tools to support workforce recruitment, engagement, retention, succession planning, diversity, culture and models for the future.

In addition, the AHA continues to advocate for the highest level of appropriations for nursing and allied health education programs (refer to the “Annual Appropriations” issue paper). We also recommend Congress continue its support of the education of future physicians through the Medicare graduate medical education program.

Visas. The AHA supports streamlining and improving the immigration process to allow qualified, internationally educated nurses, physicians and allied health professionals to work in this country. We continue to work with Congress and the administration to improve immigration 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 recommend 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. That’s why the AHA supports the Resident Physician Shortage Reduction Act of 2013 (S. 577/H.R. 1180), introduced by Sens. Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV), and Rep. Joe Crowley (D-NY), respectively. The bill would increase the number of Medicare-supported physician training positions to at least 15,000 new resident positions, which is about a 15 percent increase in residency slots.

Employee Relations. America’s hospitals recognize and appreciate the compassion, hard work and dedication their employees demonstrate in caring for patients and communities, which is why hospitals view employee relations as a top priority. 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. We continue to oppose certain organized labor-supported initiatives that would interfere with hospitals’ ability to work directly with their employees to enhance the work and patient care environments. In 2013, labor and employment activities will continue to be concentrated in various regulatory agencies and the courts. Here is a snapshot of issues that may be in play in 2013:

National Labor Relations Board (NLRB). A recent decision from the federal appeals court in the District of Columbia (DC), Noel Canning v. NLRB, ruled
that three members of the NLRB were unlawfully appointed in January 2012, and the NLRB therefore lacked a quorum to conduct official business. The ruling potentially calls into question previous and future actions of the current board. The court’s reasoning in the case is very broad and arguably suggests that the absence of a quorum potentially could invalidate a number of official actions taken by previous boards, including the promulgation of the expedited union elections regulation – a rule that is already the subject of a continuing legal challenge brought by the U.S. Chamber of Commerce and the Coalition for a Democratic Workplace (CDW). The AHA, ASHHRA and AONE are members of the CDW and joined the HR Policy Association and Society for Human Resource Management in filing a friend-of-the-court brief supporting the Chamber and CDW challenge of the rule.

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 may 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 (and even the AHA) that is necessary to ensure proper compliance with all applicable laws.

In addition, the department’s Office of Federal Contract Compliance Programs (OFCCP) continues its efforts to expand the agency’s regulatory and enforcement reach over hospitals, asserting that hospitals are federal contractors or subcontractors solely because of the hospital’s participation in certain federally sponsored health care reimbursement programs like TRICARE, the U.S. Department of Defense health care program that provides coverage to military personnel. The DOL’s Administrative Review Board (ARB) in October 2012 issued its long-awaited decision in OFCCP v. Florida Hospital of Orlando, rejecting OFCCP’s position that Florida Hospital was a federal subcontractor based on its participation in TRICARE. The AHA and ASHHRA submitted a friend-of-the-court brief in support of the hospital. However, the OFCCP filed a motion asking the ARB to reconsider its decision. While it is unclear when the ARB will rule on the OFCCP’s motion for reconsideration, it is clear from the agency’s arguments that it plans to continue to claim that hospitals participating in TRICARE are government contractors subject to OFCCP’s oversight and enforcement. The AHA will continue to monitor OFCCP’s actions and intervene when appropriate.
Legislation. On the legislative front, the AHA and ASHHRA will continue to oppose efforts that limit hospitals’ flexibility to determine appropriate staffing patterns for health care workers. Many factors influence a hospital’s staffing plan to ensure patients receive appropriate care, including the experience and education of its nursing staff, the availability of other caregivers, patients’ needs and the severity of their illnesses, and the availability of technology. Another major consideration is the availability or supply of nurses themselves. The demand for registered nurses and other health care personnel will continue to rise as the number of patients seeking care increases due to the aging of “baby boomers” and the number of people with health coverage grows with ACA implementation beginning in 2014.

The AHA and ASHHRA also will continue to vigorously oppose any legislative effort to amend the National Labor Relations Act (NLRA) and reverse existing NLRB guidance on when charge nurses are considered supervisors. Legislation introduced in the past would have removed two functions from the NLRA definition of supervisor – “assigning” and “responsibly directing” other employees. Removing these functions from the NLRA definition of “supervisor” would enable supervisors to be eligible for inclusion in the collective bargaining unit and subject to all union work rules and discipline.

Current NLRB guidance on when charge nurses are supervisors strikes a reasonable balance in establishing the criteria for when charge nurses function as supervisors. Not every charge nurse is a supervisor – it is their responsibilities that make the determination. On a day-to-day basis, charge nurses are often the most visible individuals “in charge” of a hospital unit, stepping in when there is a crisis or conflict and providing a management voice to patients, families and other employees. We must preserve the ability of charge nurses to carry out their roles as the voice of management without being subject to conflicting loyalties and threats of union discipline.
Hospitals play a key role in the nation’s emergency preparedness and response as part of America’s health care infrastructure. In times of disaster, communities look to hospitals not only to mobilize resources to care for the ill and injured but also to provide food and shelter, and coordinate relief and recovery efforts. As part of this standby role to communities, hospitals are pivotal to disaster-response activities, whether they are rural, critical access hospitals (CAHs) or Level 1 trauma centers. While hospitals have always had emergency operations plans in place, disasters such as the terrorist acts of September 11, Hurricane Katrina, the Joplin tornado, the threat of pandemic influenza and, most recently, the devastation caused by Hurricane Sandy, have broadened expectations about the type and impact of disasters that hospitals could experience and raised the bar for emergency preparedness and response.

Emergency preparedness requires a significant investment in staff and resources. Hospitals must be prepared to provide care and, as a result, they are expected to develop and test disaster response plans, train clinical and support staff, maintain and replace disaster response equipment and supplies, ensure communication and surveillance capabilities and enable patient transport and care. Yet, hospitals must shoulder this expanding challenge while also facing additional costs associated with the Patient Protection and Affordable Care Act, growing uncompensated care, labor shortages, rising pharmaceutical and technology expenses, increasing Medicaid pressures and decreasing reimbursements from Medicare and private payers.

In this difficult financial environment, hospitals depend on federal hospital emergency preparedness funding to help support their preparedness activities. Unfortunately, federal preparedness funding has not kept pace with the increasing demands placed on hospitals to ensure they are ready to respond to any disaster that hits their community. The federal government must help protect the nation by providing greater resources to hospitals to meet the challenges of emergency preparedness and ensuring that these resources are made available in a timely manner.

The Hospital Preparedness Program (HPP), the primary grant program for hospital emergency preparedness, has provided funding to enhance hospital preparedness and response for the past 11 years and is critical to hospitals’ ability to continue to be prepared. While the recently passed Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 addresses our national medical and public health preparedness and response capabilities, the AHA is disappointed that the bill reauthorizes funding at $375 million per year, a level that is nearly $100 million less than the amount authorized in the 2006 Pandemic and All-Hazards Preparedness Act. Furthermore, the annual appropriations for the HPP have declined nearly 30 percent since the program began in fiscal year 2003.
Cuts of this magnitude undermine preparedness and diminish the ability of the nation’s hospitals to respond in the event of a large-scale disaster. **The AHA will continue to work with Congress and the Obama administration to ensure that funding earmarked for hospital preparedness is sustained.**

**Aligning the Process for Updating Hospital Safety Standards.** In light of the hospital lessons learned from Hurricane Sandy, particularly those involving widespread power outages and the failure of generators, federal agencies and accrediting bodies are examining whether changes need to be made to existing regulations and accreditation standards. The Centers for Medicare & Medicaid Services (CMS) is examining the physical environment requirements for hospitals under the Medicare Conditions of Participation (CoPs). In addition, The Joint Commission (TJC) is analyzing the impact of Hurricane Sandy on hospitals and other health care organizations in order to compile lessons learned from this natural disaster. These lessons learned will inform future decisions about whether changes should be made to TJC standards or survey processes for hospitals. **The AHA has strongly encouraged CMS to review TJC’s analysis before the agency proposes changes in the physical environment CoPs.**

Another organization that consistently updates its standards to reflect new knowledge stemming from provider organizations’ experiences in disasters is the National Fire Protection Association (NFPA), via its Life Safety Code (LSC). The LSC contains building safety standards for hospitals. Currently, the Medicare CoPs require hospitals to follow the 2000 LSC edition, despite the fact that the LSC has been updated four times since then. **The AHA has repeatedly recommended that CMS defer to the most up-to-date LSC standards, which include updated standards for emergency lighting and emergency power for health care facilities, as a way to ensure that hospitals maintain a safe environment of care.** The AHA has advised that CMS adopt a regulatory process that requires hospitals to stay current with the LSC as it is updated every three years. In addition to emergency lighting and power, adopting the most current LSC will update CMS references to many other vital hospital infrastructure systems, including medical gas, fire alarm, sprinkler, electrical distribution, ventilation and standards for emergency management.
Federal Tax Reform and its Implications for Hospitals

**Background**

Reforming the nation’s federal tax code is a high priority for both President Obama and congressional leaders. The House Ways and Means Committee held 20 hearings on comprehensive tax reform during the last Congress and released a financial products discussion draft in January 2013. In February, Chairman Dave Camp (R-MI) and Ranking Member Sander Levin (D-MI) announced the formation of 11 separate Ways and Means Committee Tax Reform Working Groups. Also during the last Congress, the Senate Finance Committee began a comprehensive review of America’s tax system and held numerous roundtable discussions and hearings to study the specifics. They are now working on a detailed tax reform proposal intended to attract bipartisan support.

Proposals from some in both parties recommend the limitation or replacement of tax-exempt bonds. In addition, the Bowles-Simpson Commission recommended that tax-exempt bonds be replaced with direct-pay bonds. Tax changes also have figured prominently in the debate over the federal budget. In particular, under recent presidential and congressional proposals, investors with adjusted gross income exceeding certain income thresholds would no longer receive the full benefit of various tax deductions, adjustments and exemptions. This includes limiting the current full tax-exemption on interest earned from tax-exempt hospital bonds. One proposal, originally included in the president’s 2012 budget, would place a 28 percent cap on the exemption, which would effectively impose an 11.6 percent tax on otherwise tax-exempt interest for investors in the 39.6 percent tax bracket.

Proposals to limit the deduction for charitable contributions also have appeared in recent years, in some cases as part of broader tax reform proposals that lower rates, and in other cases for the purpose of raising taxes to fund specified levels of government spending. Examples of these restrictions include: limiting the tax rate against which contributions may be deducted; a dollar cap on total itemized deductions; a floor below which contributions may not be deducted; and the replacement of the deduction with a tax credit available regardless of whether the taxpayer itemizes. Different types of limitations could have varying effects on giving.

**AHA View**

**Tax-exempt Financing.** It is essential that America’s hospitals have access to needed capital to improve community health, increase jobs and support the local economy. Better access to capital helps hospitals upgrade facilities, meet growing patient needs and invest in clinical and information technology. But, many hospitals struggle to obtain adequate capital financing.

Moody’s Investors Service is maintaining its negative outlook for the “US Not-for-Profit Healthcare Sector” for 2013. The negative outlook reflects
Moody’s view that revenue growth will remain positive, but will continue to decelerate as a result of federal cuts to health care spending, limited reimbursement increases from commercial health care insurers, and a tepid economy that dampens demand for health care services. Moody’s outlook has been negative since 2008 as the recession has left a lasting impact on patient volumes, and hospitals confront significant challenges stemming from changes in how they are paid. It finds that hospitals face heightened pressure from all levels of government, as well as businesses, to lower the cost of health care services.

Non-profit hospitals and health systems would bear much of the burden of proposals that would significantly raise borrowing costs for non-profit organizations and hamper their ability to meet our country’s health and infrastructure needs.

The president proposes to place a cap on the amount of certain tax deductions and exclusions, including interest on otherwise tax-exempt bonds, that is intended to ensure that higher income taxpayers pay at least a 28 percent tax rate. Under this retroactive proposal, investors with adjusted gross incomes exceeding the thresholds set by the proposal would no longer be able to receive the full benefit of the tax-exempt interest they paid for when they purchased the bonds. This amounts to an effective 11.6 percent tax on otherwise tax-exempt interest for many taxpayers who would be in the top tax bracket. In the case of newly issued tax-exempt bonds, investors would likely demand higher interest rates to make up for this new tax.

The proposal would have a direct and negative impact on hospitals and the communities they serve. The outcome would be higher borrowing costs, fewer services, less investment in infrastructure and fewer jobs. The federal tax-exemption on municipal bond interest has been in place since the enactment of the very first federal tax code in 1913. As a result, non-profit hospital borrowers save, on average, an estimated two percentage points on their borrowing to finance investment in non-profit and public health infrastructure.

The proposed de facto tax increase would be retroactive. That is, the proposal would apply to interest on bonds hospitals already have issued, and investors, in good faith and in reasonable reliance, already have purchased. The effect would be to substantially erode the value of bonds already in investors’ portfolios. This would violate the basic assumption of investors that Congress will not change the terms governing the taxability of interest for bonds already outstanding. In the nearly 100-year history of the tax-exemption, Congress has never applied a retroactive tax to bonds already held by investors.

This new tax risk would result in higher borrowing costs for hospitals and higher health costs for the communities they serve. It is estimated that...
borrowing rates could rise by at least a full percentage point if the proposal is enacted. Hospitals will have to pay these additional costs on every bond they issue even though the tax is intended to affect those considered “wealthy.”

Proposals to eliminate entirely the tax-exemption would impose even greater costs. Proposed substitutes for tax-exempt bonds are unproven or are not financially practical for thousands of small clinics and hospitals.

Deduction of Charitable Contributions. Hospitals do more to assist the poor, sick, elderly and infirm than any other entity in health care. Since 2000, hospitals of all types have provided more than $367 billion in uncompensated care to their patients. In 2011 alone, hospitals delivered more than $41.1 billion (in costs) in uncompensated care to patients and uncounted billions more in value to their communities through services, programs and other activities designed to promote and protect health and well-being. This broad array of benefits includes basic research, medical education and unprofitable services such as burn intensive care, emergency department care, high-level trauma care and labor and delivery services.

America’s communities receive a positive return on their investment from the tax-exemption of hospitals. Federal revenue forgone because of hospital tax-exemption is an estimated 2.3 percent of hospital expenses compared to the 9.3 percent of expenses hospitals provide in community benefit.

Hospitals recognize the responsibilities that come with tax-exemption and fully appreciate the benefits. One important benefit is the ability to attract community investment through tax-deductible giving. Hospitals are the backbone of the communities they serve, and people in those communities recognize their importance through generous philanthropic giving. In fiscal year 2011, philanthropic support for nonprofit hospitals and health care organizations reached $8.9 billion, according to the Association of Healthcare Philanthropy (AHP). Needed construction and renovation projects receive almost a quarter of philanthropic dollars, but many hospitals rely on funds raised from community partners simply to meet operating expenses, allocating on average more than 15 percent of the funds they raise to general operations.

Philanthropic giving also is increasingly important as a source of capital financing as hospitals prepare to meet the health care needs of the future. Hospitals that are under significant financial strain – not profitable, not liquid and with a significant debt burden – often are shut out of traditional capital markets. They have a limited number of capital sources and incur higher costs than hospitals with a brighter financial picture. For these financially challenged hospitals, philanthropy is essential to finance the necessary facility upgrades and investments in information technology required if they are to continue to provide high-quality health care services in their communities.
Community support for hospitals is strong, but incentives are necessary to retain this critical support. The AHA is concerned that, in an environment where hospitals rely increasingly on charitable giving, limiting or eliminating the current charitable contribution deduction would reduce the availability of resources that are critical to fund hospital operations. The most recent AHP survey of hospital and health care development professionals found that nine out of 10 agreed that proposed limits on charitable deductions would result in significant reductions in giving to their organizations. About 40 percent estimate that giving would decrease between 10 and 30 percent if significant changes are made to the current tax incentives for charitable donations, which conservatively could amount to a decrease of more than a $1.07 billion in total annual giving to nonprofit hospitals and health care providers, based on AHP’s FY 2009 giving statistics.
**Background**

Momentum is growing for reforming our nation’s complex immigration system. As Congress begins to debate immigration policy, one of the most contentious policy issues will be how to deal with the undocumented (non-legal) immigrant population residing in the U.S. – whether to “legalize” them, and the extent to which this legalization will include a “pathway to citizenship.” It is likely that any legalization process will include a long period of “provisional status,” which calls into question whether federal benefits will be provided to these individuals. While some undocumented immigrants may have access to health care coverage through their employers, many are likely to remain uninsured. In effect, this population may remain without coverage during a period of transition to permanent legal status. Federal budget constraints and potential negative public reaction will impact the coverage debate. Therefore, these individuals are likely to continue to lack health care coverage for a number of years to come. Meanwhile, they may be more likely to present themselves for treatment when they are in the legalization process, because they will no longer need to fear discovery and deportation.

The best estimate of the undocumented population today is 11 million, provided by Jeffrey Passel of the Pew Hispanic Center. Of these 11 million individuals, more than 7 million are adult workers. The most recent AHA data reflect that during 2011, U.S. hospitals provided approximately $41.1 billion of uncompensated care. It is not known how much of that amount was care provided to undocumented immigrants.

**AHA View**

The AHA supports increased health care coverage for undocumented immigrants, and will work with Congress on the best method to extend coverage to this population. In addition, the AHA will urge Congress to streamline the visa process for qualified, internationally trained nurses and physicians.

**HEALTH CARE COVERAGE**

With the exception of health care services provided pursuant to the *Emergency Medical Treatment and Active Labor Act* (EMTALA), undocumented immigrants generally do not qualify for federal health care benefits. Even legal immigrants are restricted from Medicaid eligibility for at least five years under the 1996 welfare reform law, although a few states have opted to cover this population using state funds.

*The Patient Protection and Affordable Care Act* (ACA) extends insurance coverage to a substantial portion of currently uninsured populations starting in 2014. However, undocumented immigrants were specifically excluded from coverage under this law. They also are barred from any federally funded public health insurance, including Medicare, Medicaid and the Children’s Health Insurance Program.
Emerging Immigration Reform “Plans.” In late January, both the president and a bipartisan group of senators announced separate plans that establish a framework for comprehensive immigration reform, including a legalization process for those now here illegally. Both plans address border security, worksite verification, employment-based immigration, family reunification, streamlining the immigration process, adjusting the number and distribution of visas available, and a host of other technical immigration issues. Additionally, both plans would allow individuals who are unlawfully present in the U.S. to remain in the country on a “probationary” status while they undergo background checks, the payment of fees, taxes and fines, and work to meet the requirements for citizenship or a more permanent status, such as a green card (lawful permanent residence) that can lead to citizenship. Current restrictions preventing immigrants from accessing federal health care benefits also will apply to lawful probationary immigrants under both the president’s and the bipartisan Senate plan.

As the debate on immigration reform moves forward, the AHA believes that immigration reform principles must address access to health care coverage for immigrants placed on a “probationary” status and assistance to hospitals to help defray the cost of uncompensated care that may result from treating this population under EMTALA.

VISAS FOR HEALTH CARE PROFESSIONALS
Registered Nurses (RNs). Despite the slight improvement due to the effects of the recession, shortages of RNs are predicted to continue, especially in light of ACA implementation. Internationally educated RNs have played a vital role in U.S. health care. In 2006, approximately 15 percent (roughly 15,000 per year) of newly licensed RNs were immigrants, most coming to the U.S. on an employment-based (EB) visa, which is available to a number of professionals and is also known as a “green card.” However, visa backlogs began in 2007, and the waiting period for a nurse currently applying for a visa is six years or more under current law. The limit on visa allocations (140,000 EB visas per fiscal year) is statutory, set by the Immigration and Nationality Act, and only Congress can change it.

In order to immigrate to the U.S., internationally educated RNs must meet stringent standards. Every nurse, whether they are educated in the U.S. or abroad, must take the same licensing exam and meet all state requirements in order to be licensed to practice as an RN. In addition, foreign-born RNs must obtain a VisaScreen certificate that ensures that the educational program attended by the foreign nurse meets U.S. standards, that the nurses’ foreign license is valid, and that the nurse has demonstrated a command of oral and written English.

The recent comprehensive immigration reform draft proposals are silent on nurse immigration, although there are statements of intention to liberalize skilled immigration rules, which would positively impact nurse immigration.
Physicians. About one quarter of physicians admitted to residency programs each year have been trained abroad. While many of these are U.S. citizens who attended off-shore medical schools, more than half (as many as 4,000 per year) are foreign nationals. Most of these foreign physicians come on J-1 exchange visas with a requirement to return home for two years after completing their post-graduate training. A high percentage elect to stay and must pursue an arduous waiver process. Immigration of foreign physicians is not addressed in either draft reform proposal.

The AHA supports streamlining the immigration process to remove impediments and increase the supply of well-qualified, internationally educated RNs and physicians who emigrate to the U.S.
Program Integrity

In recent years, the Centers for Medicare & Medicaid Services (CMS) has drastically increased the number of program integrity auditors that review hospital payments to identify improper payments. CMS’s audit contractors focused on improving payment accuracy include recovery audit contractors (RACs) and Medicare administrative contractors (MACs). Medicare and Medicaid RACs are charged with identifying improper Medicare and Medicaid fee-for-service payments – both overpayments and underpayments. RACs are paid on a contingency fee basis, receiving a percentage of the improper payments they identify and collect. MACs serve as providers’ primary point-of-contact for enrollment and training on Medicare coverage, billing and claims processing. They also conduct pre-payment and post-payment audits.

No one questions the need for auditors to identify billing mistakes; however, many auditors conduct redundant audits that drain time, funding and attention that could more effectively be focused on patient care. For example, according to AHA’s RACTrac survey of 2,300 participating hospitals, there was a 61 percent increase in the number of records requested for RAC audits during 2012. These Medicare claims now collectively represent more than $6 billion in Medicare payments, an 83 percent increase from the claims requested for RAC audits through 2011. In addition, RACTrac data show that hospitals appeal about 41 percent of all Medicare claims denied by a RAC, and in such cases, hospitals are successful at overturning the RAC denial 72 percent of the time.

Hospitals are drowning in the deluge of unmanageable medical record requests and inappropriate payment denials. CMS and Congress need to make the audit processes more fair and transparent.

AHA View

Hospitals take seriously their obligation to properly bill 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. The AHA recognizes the need for auditors to identify billing errors; however, redundant government auditors, unmanageable medical record requests and inappropriate payment denials are wasting hospital resources and contributing to growing health care costs. More oversight is needed by CMS of audit contractors to prevent inaccurate payment denials and to make its overall auditing effort more transparent, timely, accurate and administratively reasonable.

Audit Relief through Legislation. Introduced by Reps. Sam Graves (R-MO) and Adam Schiff (D-CA), the Medicare Audit Improvement Act of 2013 (H.R. 1250), proposes transparent and fair audit practices and assistance to hospitals in mitigating excessive overall audit burden. This AHA-supported legislation would establish annual limits on documentation requests from RACs, impose financial penalties on RACs if they fall out of compliance with program requirements,
make RAC performance evaluations publicly available and allow denied inpatient
claims to be billed as outpatient claims if necessary, among other provisions. In
addition, the bill would limit the number of “additional document requests” to
2 percent of hospitals claims, with a maximum of 500 per 45 days. H.R. 1250
also would require a physician to review the claim. Currently, RAC and MAC
programs are allowed to have non-physician auditors review and deny care that
a physician determined was necessary for a patient.

**RAC Relief through the Courts.** Medical necessity represents the top reason
RACs deny claims; however, roughly half of the medical necessity denials were
for claims where the RAC claimed treatment should have been provided on an
outpatient basis rather than on an inpatient basis, not because the care was
medically unnecessary. In these cases, CMS denies the claim in full and only
permits the hospital to rebill for selected ancillary Part B services (e.g., diagnostic
laboratory tests and x-rays), rather than for full Part B payment. In a complaint
filed Nov. 1, 2012, with the U.S. District Court for the District of Columbia,
the AHA and five hospital organizations asked the court to both overturn the
nonpayment policy and direct the government to reimburse hospitals that have
been denied payment for these medically necessary services.

**CMS Responds.** In response to the lawsuit, on March 13 CMS issued two
regulations: an “Administrator’s Ruling,” which made immediate (temporary)
changes to its prior rebilling policy, and a proposed rule, which would implement
a permanent change. The Administrator’s Ruling allows hospitals to seek Part B
payment when claims are denied by a Medicare auditor as not medically necessary
under Part A. The ruling applies to all new denials after March 13, prior denials
that are still eligible for appeal, and appeals currently in process. Under the ruling,
however, hospital would not be permitted to bill for those services that “require
an outpatient status” for the time period the beneficiary spent in the hospital as
an inpatient. The proposed rule limits rebilling to only those claims for services
provided in the prior year. While CMS attempts to provide a permanent solution
to rebilling problems, the AHA remains concerned that the proposed rule
applies only to services provided within the previous year. Since RACs often
review claims that are more than a year old, the practical effect would be
many denials would be ineligible for rebilling. Therefore, the AHA intends
to press ahead with the litigation, unless and until a final rule provides full
Part B reimbursement without unreasonable restrictions. We also will use
the comment process to urge the agency to adopt a final rule that ensures that
hospitals receive full reimbursement for all reasonable and necessary services
provided to Medicare beneficiaries both in the past and in the future.

**Preventing Improper Payments.** CMS must invest in 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
backlog that exist for auditors and the appeals process. The AHA continues to urge CMS to offer more substantial 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 has member educational resources to help hospitals better understand the RAC and Medicare appeals processes. A series of Member Advisories and Audit Education webinars can be accessed through AHA’s RAC policy portal under “Education and Tools” at www.aha.org/rac.
Administrative Simplification & ICD-10 Implementation

Background
With the implementation of health care reform, there has been a great deal of interest in reducing the complexity and cost associated with administrative insurance requirements in health care. Administrative simplification efforts are needed to make health care more affordable and reduce the amount of time providers spend on administrative tasks. Originally adopted as a part of the Health Insurance Portability and Accountability Act (HIPAA), administrative simplification required standardized electronic transactions between health plans and providers. HIPAA’s scope reaches the majority of health plans with limited exceptions for government programs.

The administrative simplification provisions of the Patient Protection and Affordable Care Act (ACA) call for the adoption of operating rules for each HIPAA transaction standard to improve their efficiency and effectiveness. The operating rules are intended to reduce variation in how individual health plans and clearinghouses actually implement the HIPAA transaction standards by adopting standardized best practices. The rules also seek to establish performance expectations on the electronic response to an inquiry to ensure a satisfactory response time. The ultimate goal of these new operating rules is to reduce administrative burden and cost for all parties.

AHA View
Operating Rules. With support from the AHA, the Council for Affordable Quality Healthcare’s (CAQH) Committee on Operating Rules for Information Exchange (CORE) has been designated as the authoring body responsible for the advancement and creation of all operating rules. This multi-stakeholder initiative is developing operating rules that support interoperability between payers and providers. The AHA successfully advocated for revising the CORE’s governance model to include a balanced number of provider and health plan representatives.

Since enactment of the ACA, the AHA has worked closely with CAQH to expand provider input into the development of operating rules by CORE as well as broader CAQH activities. CAQH has established a Provider Council to more formally engage a broader range of participants in CAQH. Co-chaired by AHA President and CEO Rich Umbdenstock, the Provider Council’s charge is to provide input into existing CAQH initiatives and research, and participate in idea development to increase efficiencies and reduce costs. The AHA also has worked closely with CAQH on the new governance process for CORE and on recommending several hospital and health system individuals to serve on CORE’s new board.

At the AHA’s urging, the ACA included legislative language that requires health plans to file a statement with the Department of Health and Human Services
(HHS) certifying that their data and information systems are in compliance with the HIPAA standards and the corresponding operating rules starting Dec. 31, 2013. Failure to adhere to the operating rules will result in significant penalties for a health plan that is non-compliant. Key compliance dates for operating rules are as follows:

- Jan. 1, 2013 – Eligibility and claim status
- Dec. 31, 2013 – Health plans must certify their information systems are in compliance with the above operating rules
- Jan. 1, 2014 – Electronic funds transfer and electronic remittance advice
- July 1, 2014 – Adoption of other transaction operating rules
- Jan. 1, 2016 – Effective date for using operating rules for other transaction standards (such as claims or enrollment)

The AHA will continue to actively participate in the development of operating rules in collaboration with state and other national hospital associations. We encourage hospitals to join CORE to ensure that the hospital perspective is fully voiced.

ICD-10. In 2009, HHS mandated adoption of new International Classification of Diseases (ICD) standards, or ICD-10. This replacement to the outdated ICD-9 coding system is long overdue, and it will provide greater precision in the classification of disease. In 2012, HHS announced a one-year delay in ICD-10 implementation, until Oct. 1, 2014. The delay was prompted in part by problems implementing a new version of the HIPAA transaction standards that interrupted payments for some hospitals and physician offices, as well as by growing evidence that small providers were behind in the implementation process. The AHA supported this short, 12-month delay based on a survey of AHA members that indicated 70 percent of responding hospitals thought that a short delay in ICD-10 compliance would be helpful given the many competing initiatives, including health reform implementation and the adoption of electronic health records. The AHA also recommended that HHS keep the transition for both diagnoses and procedures (ICD-10-CM and ICD-10-PCS) on the same timeline. CMS recently reiterated that no further delay is expected with ICD-10 implementation – Oct. 1, 2014 remains firm. To help hospitals prepare for this significant transition, the AHA has launched extensive educational programs.
Medical Liability Reform

Background

The high costs associated with the current medical liability system not only harm hospitals and physicians, but also patients and communities. Across the nation, access to health care is being negatively impacted as physicians move out of states with high medical liability insurance costs or stop providing services that may expose them to a greater risk of litigation. The increased costs that result from our flawed medical liability system not only hinder access to affordable health care, they also raise health care premiums and costs for everyone.

AHA View

The AHA supports a more sensible liability system that uses evidence-based standards, reduces frivolous lawsuits, and produces prompt and fair compensation for injured patients. Specifically, the AHA seeks to:

- Model federal proposals on proven state models of reform;
- Cap non-economic damages;
- Allow the courts to limit lawyers’ contingency fees;
- Make each party liable only for the amount of damages directly proportional to its responsibility; and
- Enact a reasonable statute of limitations after the date of the manifestation or discovery of an injury.

In previous years, several bills were introduced that would have helped curb skyrocketing medical liability costs. In 2013, we anticipate legislators will re-introduce several bills from the previous congressional session, including the most comprehensive medical liability reform bill thus far, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act. This AHA-supported legislation is modeled after reform enacted in California during the 1970s, and would:

- Cap compensation for pain, suffering and emotional distress – non-economic damages – at $250,000;
- Cap punitive damages at $250,000 or two times the award for economic damages, whichever is greater;
- Replace “joint-and-several” liability, which makes any defendant in a suit liable for all the damages, with a fair-share rule that sets damages for defendants in proportion to their share of responsibility for the injury;
- Allow defendants to inform juries of workers’ compensation payments and other outside benefits for injured parties that could be subtracted from jury awards;
- Set the statute of limitations for filing a liability suit at a maximum of three years, with more lenient terms for injured children younger than age six; and
• Limit the amount of a jury verdict that plaintiffs’ attorneys can receive in the form of contingency fees.

In addition, the issue of states’ rights is increasingly relevant to the development of federal medical liability reform legislation. Several lawmakers who support meaningful reform do not favor a federal solution that would supersede state laws. Therefore, we expect that legislative proposals will carefully protect state reforms that are already in place.

Finally, the AHA also supports an administrative compensation system (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.