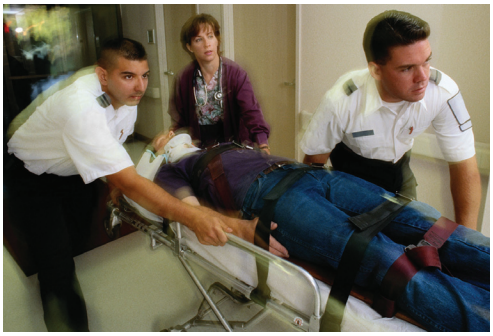
American Hospital Association®

The Value of AHA Membership for Public Hospitals



Public and safety-net hospitals play a vital role in our nation's health care system, delivering care and providing access to essential health and social services in underserved communities. In more than 29 cities, public hospitals provide all levels of trauma care and operate 44% of the nation's burn care units. This is especially striking considering public hospitals represent just 2% of the nation's hospitals. In addition, more than half of public hospital patients are racial and ethnic minorities, and a majority of patients are uninsured or qualify for Medicaid. Public hospitals have long led the health care field in providing quality care to diverse and vulnerable communities. Public hospitals are especially committed to helping reduce racial, ethnic, linguistic and socioeconomic health care disparities.

Outlined below are just some of the ways the American Hospital Association (AHA) works on behalf of public hospitals.

Working for Public Hospitals

Outdated regulations, duplicative or conflicting rules, unworkable timelines – all of these increase the burden on all providers, including public hospitals, and draw much-needed resources away from patient care. The AHA time and again has demonstrated the need for streamlined regulations, common sense rules and manageable timelines, as outlined below.

- **Medicaid Disproportionate Share Hospital (DSH) Payments.** Worked with Congress to delay scheduled cuts to Medicaid DSH payments for the next three years.
- **Medicare DSH.** Helped persuade the Centers for Medicare & Medicaid Services (CMS) to reduce the size of the overall Medicare DSH cut in fiscal year (FY) 2014 from a proposed $1 billion to $550 million. CMS also will distribute uncompensated care DSH payments on a per-discharge (rather than periodic interim) basis, avoiding a potential cut in Medicare Advantage payments to hospitals of about $3 billion annually. Worked with CMS to revise cost reporting procedures to align the uncompensated care DSH payments with each individual hospital's cost reporting period. We continue to urge Congress to delay the Medicare DSH cuts contained in the Affordable Care Act (ACA).
- **Medicare Physician Payment.** Worked with Congress to prevent a 24% cut to Medicare physician payments that was scheduled to take place Jan. 1 through April 1, 2015.
- **Community Health Needs Assessments (CHNA).** Worked with the Internal Revenue Service (IRS) to revise its proposals for implementing the ACA's CHNA requirement to explicitly permit hospitals to collaborate and share a joint CHNA, as well as implementation strategy, with other hospitals. The rule also reduces some of the detailed documentation that was proposed. Importantly, the guidance on how the IRS will respond to noncompliance recognizes, as the AHA had urged, that not all infractions are of the same significance and creates a three-tiered approach to sanctions for noncompliance.
- **Medicare Conditions of Participation (COPs).** Successfully urged CMS to propose rescinding a new requirement that hospital governing boards include a medical staff member. This provision was problematic for a number of reasons, including the fact that some hospitals, especially those that are publically operated, have boards that are elected or appointed. CMS instead proposes to require consultation with the medical staff.
- **State Provider Assessments.** Successfully urged Congress not to restrict states' use of Medicaid provider assessments as a way to pay for legislation to freeze student loan interest rates. Republican leaders had proposed, as one offset option, reducing the Medicaid provider assessment threshold from 6% to 5.5% to pay for a one-year extension of a student loan interest rate bill.
- **Recovery Audit Contractors (RAC).** Along with limitations on RACs related to the two-midnight policy, in response to concerns voiced by AHA, CMS is making a number of changes to the RAC program, effective with the next round of contracts. CMS will encourage use of the pre-appeal discussion period to resolve disputes over RAC audits by requiring RACs to promptly acknowledge hospitals' requests for a discussion. Further, CMS will prohibit RACs from referring denied claims for recoupment until at least 30 days has passed, so that hospitals are not forced to choose between using the discussion period and appealing the claim. CMS also will establish limits on the number of medical records RACs can review based on claim type, and will adjust hospitals' medical records limit based on error rate. Also, in January, AHA launched a new online tool that allows hospitals to compare the impact of Medicare's RAC program based on RAC region, bed size, ownership status and other variables. Hospitals can use the RACTrac Analyzer with AHA's existing RACTrac survey to create reports that compare their hospital's RAC activity with those of similar hospitals.
- **Two-midnight Policy.** Secured several partial enforcement delays of CMS's two-midnight policy for inpatient admission and medical review criteria. Under the enforcement delay, recovery auditors and other Medicare review contractors will not conduct post-payment patient status reviews of inpatient hospital claims with dates of admission on or after Oct. 1, 2013 through March 31, 2015. AHA continues to urge CMS to fix the critical flaws of the underlying policy by immediately engaging stakeholders to find a workable solution that addresses the reasonable and necessary inpatient-level services currently provided by hospitals to Medicare beneficiaries that are not expected to span two midnights.

- **Rebilling.** At the urging of AHA and others, CMS recognized that physical therapy, speech-language pathology and occupational therapy services were incorrectly classified in its proposed rebilling rule as services requiring outpatient status, and revised the final rule accordingly to permit hospitals to rebill them.
- **Conrad State 30 J-1 Visa Waiver Program.** Worked with Congress to approve legislation extending through September 2015 the Conrad State 30 J-1 visa waiver program, which allows foreign-born physicians to remain in the U.S. for three years after medical school to serve in medically underserved areas.
- **Stage 3 Meaningful Use.** Secured a delay until FY 2017 for the start of Stage 3 requirements for meaningful use of electronic health records (EHR) under the Medicare and Medicaid EHR Incentive Programs. AHA welcomed the one-year delay in the Stage 3 start date, and continues to work to address its more immediate concerns with Stage 2. AHA also helped secure an expanded hardship exception for penalties for failure to meet meaningful use that begin in FY 2015.
- **EHR and Method II Billing.** Convinced CMS to take steps to ensure that certain physicians who provide services in outpatient departments of CAHs are eligible to participate in the Medicare EHR Incentive Program beginning 2013. Secured extra time for physicians to complete their online attestations for meaningful use, and a one-time window for hospitals to attest to meeting meaningful use after the deadline for FY 2013.
- **Protections for Health IT Donations.** Consistent with AHA input, CMS and the Department of Health and Human Services (HHS) Office of Inspector General extended through 2021 the regulatory protections under the Stark and antikickback laws for health IT donations from hospitals to physicians. The protections were set to expire in 2013. AHA continues to urge the agencies to make the protections permanent.
- **Emergency Medical Treatment and Labor Act (EMTALA).** Convinced CMS not to expand the current EMTALA regulations. The agency said that a hospital has satisfied its EMTALA obligation when it admits an individual "in good faith in order to stabilize the [emergency medical condition]."

Engaging Public Hospital Executives

Public hospital executives have a strong and valued voice in the AHA. They help shape key advocacy activities, policy positions and member services of particular interest to public hospital leaders through their active involvement in many forums.

- **A Role in Governance and Policy-Making.** The AHA offers public hospital executives many opportunities to take an active role in shaping AHA policies and setting direction for the association. They can play a formal role in association governance and policy formation by serving on the AHA's Board of Trustees, Regional Policy Boards, Governing Councils and committees. In addition, the association creates short-term advisory and work groups where members weigh in on more focused, time-sensitive policy issues.
- **AHA Section for Metropolitan Hospitals.** The AHA Section for Metropolitan Hospitals currently has almost 1,000 members from across the country and includes CEOs from public, metropolitan/urban, suburban, and teaching hospitals. The Section provides forums linking members with shared interests and missions to advise AHA on policy and advocacy activities and to discuss issues of great importance to metropolitan and public hospitals and the field as a whole. These efforts are led by the Metropolitan Hospitals Governing Council, which meets at least three times a year. Valuable opportunities are also provided for public hospital leaders to interact and network with one another through special member conference calls and meetings.
- **AHA Section for Small or Rural Hospitals.** The AHA Section for Small or Rural Hospitals has more than 1,600 members. The Section provides educational and technical assistance through webinars and workshops; past webinars focused on navigating the drug shortage and hospital/federally qualified health centers relations. In addition, members receive updates, alerts and information about federal policy changes affecting rural hospitals including payment, quality and delivery system reforms. The Section is led by a governing council comprising small, rural hospital leaders from around the country.
- **Advocacy Alliances.** The AHA's *Advocacy Alliances* provide members with another way to engage legislators on the specific issue or issues that have a direct impact on their ability to continue providing quality health care services in their communities. The **Advocacy Alliance for the 340B Drug Pricing Program** focuses primarily on preventing attempts to scale back this vital drug discount program and supports expansion of 340B discounts. The **Advocacy Alliance for Graduate Medical Education** focuses on advocacy related to graduate medical education funding and ensuring an adequate supply of physicians. The **Advocacy Alliance for Coordinated Care** focuses on ensuring payment rates remain fair and equitable in the hospital outpatient setting for evaluation and management and other services, and for post-acute care providers. The **Advocacy Alliance for Rural Hospitals** focuses on extending Medicare provisions critical to rural hospitals. In addition, this Alliance continues to work to protect critical access and other rural hospital designations.
- **Member Outreach.** Several times throughout the year AHA's public hospital member CEOs are individually contacted by AHA staff and/or are invited to participate in small group CEO conference calls to discuss key AHA initiatives. During the calls members contribute their perspectives and often receive additional tools and resources to address key challenges shared during the discussions.

Providing Key Resources for Public Hospitals

Membership in the AHA means more than representation on critical regulatory and legislative issues. AHA offers public hospital leaders the tools and resources to navigate today's changing landscape of health care delivery and to support efforts to improve quality of care for the communities served.

- **Equity of Care.** The National Call to Action to Eliminate Health Care Disparities, supported by AHA along with the American Association of Medical Colleges, American College of Healthcare Executives, Catholic Hospital Association and America's Essential Hospitals, exists to provide tools and resources to the field that eliminate health care disparities. The group focuses on three core areas: the collection and use of race, ethnicity and language preference data; cultural competency training and diversity at the governance and leadership ranks. Best practices, case studies and monthly newsletters can be found at www.equityofcare.org.
- **Policy Reports and Research.** The AHA's Committee on Research (COR) develops the AHA research agenda, studies topics in depth and reports out to the AHA Board and the field. The COR's recent report, *Your Hospital's Path to the Second Curve: Integration and Transformation*, outlines potential paths to managing life in the gap and achieving the Triple Aim. Other AHA research reports have focused on hospitals' essential standby role in providing emergency and trauma care, patient engagement and advanced illness management.
- **HPOE Guides and Reports.** The AHA's Hospitals in Pursuit of Excellence (HPOE) shares action guides and reports to help accelerate performance improvement. For example, *Value Based Contracting* is a primer for hospitals and health care systems as they transition to value-based contracting arrangements and assume more risk, and *The Second Curve of Population Health* builds upon prior AHA reports that outline a roadmap for hospitals to use as they transition to the second curve of population health. The recent *Integrating Behavioral Health Across the Continuum of Care* explains the value of integrating physical and behavioral health services and the importance of measuring integration efforts.
- **Great Boards.** The Great Boards website and newsletter reports on governance trends and effective practices with a current focus on strategic governance practices for turbulent times. Sample policies, practices and tools are provided for hospital boards of trustees.
- **ICD-10 Executive Action Guide.** The AHA's ICD-10 Executive Action Guide helps hospital and health system leaders with their transition to the new ICD-10 coding system. The guide highlights four areas that are critical to implementation and provides a roadmap to benchmark progress.
- **AHA Resource Center.** Highly trained information specialists assist members in accessing timely and relevant health services articles and data.
- **Advocacy Action Center.** This Web-based kit provides a set of resources and materials tailored to help hospital executives effectively communicate key messages and explain concerns to legislators, the hospital family and the community at large. These resources can also be accessed through AHA's mobile app, available for both Apple and Android-based devices.