



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 American Hospital Association (AHA) works to ensure the unique needs of these organizations are a national priority. Below are just some of the ways the AHA works for teaching hospitals.*

## Working for Teaching Hospitals

*Payment shortfalls, workforce shortages, and outdated and duplicative regulations increase the burden on teaching hospitals. In recent months, the AHA has worked with members to stave off cuts to funding for graduate medical education and to demonstrate the need for streamlined regulations, commonsense rules and manageable timelines. The success of some of our joint efforts are outlined below.*

- Two-midnight Policy.** Secured several partial legislative and regulatory enforcement delays of the Centers for Medicare & Medicaid Services' (CMS) 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.
- 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.
- 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.
- Graduate Medical Education (GME).** Successfully defended proposals by the administration, some in Congress and various deficit reduction commissions to cut Medicare indirect medical education (IME) and direct GME payments.
- New Teaching Hospitals.** The ability of hospitals to train the next generation of physicians is crucial to the future success of the American health care system. The AHA worked with CMS to finalize a policy to increase the cap-building period for new teaching hospitals from three to five years.
- 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 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. The AHA continues to urge Congress to delay the Medicare DSH cuts contained in the Affordable Care Act (ACA).
- 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.
- 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.

- **Conditions of Participation (CoPs).** Successfully urged CMS to revise many outdated CoPs for hospitals. The improvements included allowing multi-hospital systems to operate with a single governing board. AHA will continue to work with CMS to allow multi-hospital systems to operate with a unified medical staff.
- **Outpatient Prospective Payment System.** Helped persuade CMS to delay implementing the comprehensive ambulatory

payment classifications until calendar year (CY) 2015 due to insufficient and erroneous data impacts in the proposed rule. The additional time will allow for public review and comment as well as review by CMS's Advisory Panel on Hospital Outpatient Payment. CMS also made a number of other modifications to its proposed rule in response to AHA's advocacy efforts, including not collapsing the 10 emergency department visit codes into a single code in CY 2014 and modifying some of its packaging proposals.

## Engaging Teaching Hospital Executives

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

- **A Role in Governance and Policy-Making.** The AHA offers teaching 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 the Committee on Clinical Leadership. 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 teaching, public, metropolitan/urban and suburban 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 teaching 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 teaching hospital

leaders to interact and network with one another through special member conference calls and meetings.

- **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 Graduate Medical Education** focuses on advocacy related to graduate medical education funding and ensuring an adequate supply of physicians. 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 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.
- **Member Outreach.** Several times throughout the year, AHA's teaching 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 Teaching Hospitals

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

- **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.

- **AHA's Physician Leadership Forum (PLF).** The PLF seeks to foster a strong collaborative relationship between hospitals and physicians through education, quality and patient safety, leadership development, and advocacy and public policy. The PLF has focused on team-based care, physician competency development and physician practice management.
- **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.