



2014 Advocacy Agenda

Transforming the Health Care Delivery System

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Delivery System Reform Programs

Background

Many hospitals, health systems and payers are adopting delivery system reforms with the goal of better aligning provider incentives to improve care coordination and quality, and reduce costs. These reforms include forming accountable care organizations (ACOs), bundling services into 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.

The federal government also is working with hospital and health systems to pursue these models, with many of these activities being coordinated within the Center for Medicare & Medicaid Innovation (CMMI). The CMMI was created by the Affordable Care Act (ACA) and is intended to serve as a vehicle for transforming the delivery and payment of health care services by testing innovative payment and service delivery models to reduce program expenditures while preserving or enhancing quality. Its budget is \$10 billion for activities from fiscal years (FYs) 2011 through 2019, and \$10 billion for each subsequent 10-year fiscal period beginning with FY 2020.

AHA View

Our fragmented health care system is rapidly transforming into a more integrated delivery system where 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. As such, we urge 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 implemented automatically by law or regulation. The AHA's efforts around delivery system reform programs focus on areas described below.

CMMI Demonstration Projects. In selecting the models to test through the CMMI, the secretary of Health and Human Services (HHS) may give preference to models that improve the coordination, quality and efficiency of health care services furnished to beneficiaries, such as patient-centered medical homes. The Secretary also may limit testing of payment and service delivery models to targeted geographic areas. Payment models are evaluated based on the quality of care they incentivize, including patient-level outcomes and patient-centeredness, and the changes in Medicare spending they generate. The tested models are exempt from budget neutrality, and CMS has the discretion to terminate, modify or expand the scope or duration of the models as it sees fit. Beginning in 2012, and once every other year thereafter, the Secretary must submit a report to Congress on the progress of the CMMI.

In selecting innovations to fund under the CMMI, the Secretary has the authority to prioritize the following characteristics, among others:

- Programs that focus on providing telehealth, behavioral health, stroke and non-medical providers in medically underserved areas and facilities of the Indian Health Service;
- Programs that target beneficiaries with two or more chronic conditions; and
- Programs that link the public sector with private sector payers.

The current CMMI models fall into seven categories and are bulleted below.

<p>Accountable Care</p>	<ul style="list-style-type: none"> • Advanced Payment ACO model • Pioneer ACO model • Medicare Health Care Quality Demonstration • Rural Community Hospital Demonstration • Comprehensive End-stage Renal Disease Initiative • Nursing Home Value-based Purchasing Demonstration • Private, For-profit Demo Project for the Program of All-Inclusive Care for the Elderly (PACE) • Physician Group Practice Transition Demonstration (no longer active)
<p>Bundled Payments for Care Improvement (BCPI)</p>	<ul style="list-style-type: none"> • BPCI Model 1: Retrospective Acute Care Hospital Stay Only • BPCI Model 2: Retrospective Acute & Post-acute Care Episode • BPCI Model 3: Retrospective Post-acute Care Only • BPCI Model 4: Prospective Acute Care Hospital Stay Only • Medicare Acute Care Episode (ACE) Demonstration • Physician Hospital Collaboration Demonstration • Specialty Practitioner Payment Model Opportunities (under development) • Medicare Hospital Gainsharing Demonstration (no longer active)
<p>Primary Care Transformation</p>	<ul style="list-style-type: none"> • Comprehensive Primary Care Initiative • Federally Qualified Health Center Advanced Primary Care Practice Demonstration • Frontier Extended Stay Clinic Demonstration • Graduate Nurse Education Demonstration • Independence at Home Demonstration • Multi-payer Advanced Primary Care Practice • Medicare Coordinated Care Demonstration (no longer active)
<p>Initiatives Focused on the Medicaid and Children’s Health Insurance Program Population</p>	<ul style="list-style-type: none"> • Medicaid Emergency Psychiatric Demonstration • Medicaid Incentives for the Prevention of Chronic Diseases Model • Strong Start for Mothers and Newborns Initiative: Effort to Reduce Early Elective Deliveries • Strong Start for Mothers and Newborns Initiative: Enhanced Prenatal Care Models
<p>Initiatives Focused on Dual Enrollees</p>	<ul style="list-style-type: none"> • Financial Alignment Initiative for Medicare-Medicaid Enrollees • Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents

<p>Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models</p>	<ul style="list-style-type: none"> • State Innovation Models Initiative: Model Design, Pre-testing and Testing Awards • Health Care Innovation Awards • Maryland All-payer Model • Medicare Intravenous Immune Globulin (IVIG) Demonstration • Frontier Community Health Integration Project Demonstration
<p>Initiatives to Speed the Adoption of Best Practices</p>	<ul style="list-style-type: none"> • Community-based Care Transitions Program • Innovation Advisors Program • Medicare Imaging Demonstration • Million Hearts • Partnership for Patients

Currently, all 50 states and the District of Columbia have at least one model being run at the state level, in addition to innovations being tested by health care facilities.

ACOs. ACOs are groups of doctors, hospitals and other health care providers who voluntarily come together to better coordinate care to improve quality and reduce cost. Some hospitals have been participating in similar arrangements with private payers for several years. According to CMS, more than 360 Medicare ACOs have been established to date, serving more than 5.3 million beneficiaries. Notably, more than half of ACOs are physician-led organizations that serve fewer than 10,000 beneficiaries. Approximately one in five ACOs include community health centers, rural health clinics and critical access hospitals that serve low-income and rural communities.

CMS, in collaboration with the CMMI, has developed three main ACO models: the Advanced Payment ACO Model (APM), the Medicare Shared Savings Program (MSSP), and the Pioneer ACO.

- APM. In order to assist participants with the high upfront costs associated with becoming an ACO, CMS created an APM whereby qualifying participants in the MSSP can receive upfront and monthly payments to invest in their ACO infrastructure. Advanced payments are recouped from the shared savings the ACO earns. The APM model was specifically designed for physician-based and rural providers whose ability to achieve success would be improved with additional access to capital. Currently, there are 35 ACOs participating in the APM.
- MSSP. Under the MSSP, ACO participants can choose to participate in one of two tracks. Track 1 is a “one-sided” model, which has no downside risk for participants. It was designed for less experienced ACOs and allows these organizations to share in the savings but not in the losses. Track 2 is a “two-sided model” in which participants share in both the savings and the losses.

According to CMS, as of March 2013, almost all MSSP participants (98 percent) were participating in Track 1, which is available only for the first three-year agreement period.

- Pioneer ACO. The Pioneer ACO model was created for those hospitals and other providers that have more experience with coordinating care across settings. The Pioneer ACO model differs from the MSSP in three key ways: (1) its shared savings payment arrangement has higher levels of savings and risk than in the MSSP; (2) if the ACO earns savings in the first two years it is eligible to move to a population-based payment model; and (3) it must have ACO-like payment arrangements with one or more private payers.

Interim financial results for the 114 ACOs that began work in 2012 show \$128 million in savings for the Medicare program. However, only 29 of the 114 MSSP ACOs lowered expenditures enough to share in program savings. And two of these ACOs were excluded from shared savings because they failed to “successfully report” quality measures. Results for the Pioneer program are similar. According to CMS, of the 23 remaining Pioneer ACOs (the program started with 32), nine earned bonuses for achieving significantly lower spending growth while exceeding quality reporting requirements.

While hospitals and health systems are committed to the concept of accountable care, the AHA continues to have significant concerns about the design of the Pioneer ACO and MSSP models. The programs place too much risk and burden on providers with too little opportunity for reward in the form of shared savings. While CMS made extensive revisions in its final regulations to make the program more financially attractive and operationally viable – such as allowing all participants to share in first-dollar savings, eliminating down-side risk for ACOs participating in one option of the program, removing a proposed withhold of an ACO’s earned bonus, and reducing the number of quality measures to be reported – more modifications are necessary to attract additional participants.

The AHA will work with CMS as it makes modifications to the ACO programs. Some of these key changes include:

- improve the timeliness and accuracy of performance data;
- extend the Track 1 agreement period;
- set a uniform standard minimum savings rate (MSR), regardless of the number of attributed beneficiaries;
- create more achievable financial thresholds in the early years;
- implement technical adjustments to the benchmark to account for policy changes outside the provider’s control;
- allow beneficiaries to “opt in” to the ACO programs;

- allow ACOs to vary beneficiary cost sharing; and
- simplify and align quality measures, and set the required thresholds prior to the performance year.

Additionally, the AHA will work with the HHS Office of Inspector General, the Department of Justice, the Federal Trade Commission and the Internal Revenue Service regarding the legal issues around establishment of ACOs and to better facilitate clinical integration. To learn more about efforts around clinical integration, see the AHA March TrendWatch, “The Value of Provider Integration.”

Bundled Payments. Bundled payments reimburse providers a set fee for an episode of care and have the potential to promote higher quality and better coordinated care at a lower cost. Bundling is being tested in both private and public insurance markets. Currently, the largest effort is the CMS-CMMI Bundled Payments for Care Improvement (BPCI) initiative. CMS has identified 48 broad conditions for testing under the initiative. The associated diagnosis-related groups (DRGs) encompassed by these conditions account for about 70 percent of Medicare admissions. A total of 232 providers, including hospitals, physician group practices and post-acute care providers, are participating in the BPCI and had the option of starting their bundled payment model on either Oct. 1, 2013 or Jan. 1, 2014.

BPCI participants are testing four bundled payment models:

- Model 1 includes only inpatient hospitalization services for all Medicare-severity DRGs (MS-DRGs). Medicare will pay participants traditional fee-for-service payment rates, less a negotiated discount. In return, participants may enter into gainsharing arrangements with physicians.
- Model 2 includes the inpatient hospitalization, physician and post-acute services. Medicare will pay participants their “expected” Medicare payments, less a negotiated discount.
- Model 3 includes only post-acute services. Payments will be made as in Model 2.
- Model 4 includes the inpatient hospitalization, physician and related readmission services. Medicare will pay participants a prospectively determined amount.

The AHA has conducted extensive data analysis to help hospitals better understand the intricacies of a bundled payment system. (Refer to the AHA policy issue brief, “Moving Towards Bundled Payment,” for more information.) Chief among the issues addressed include considerations for:

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

The AHA supports bundled payment, including a post-acute bundle, but much work is needed to ensure that bundling is workable for patients and providers. Last year, the AHA's Hospitals in Pursuit of Excellence initiative produced "Value-Based Contracting," a primer for hospitals and health care systems as they transition to value-based contracting arrangements. In 2014, the AHA will host an educational series on bundling and additional partnerships between general acute care hospitals and post-acute providers.



American Hospital
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Improving Quality and Patient Safety

Background

Hospitals engage in an array of collaborative activities designed to improve the quality and safety of the care they provide. The increasing amount of credible and actionable information that has become available through public reporting efforts has helped spur improvements. While it is worth celebrating the improvements in patient safety and quality, such as reductions in hospital-acquired infections and early elective deliveries, it also is imperative that hospitals continue to strive for better performance.

Public policies can further facilitate or impede hospitals' efforts to improve quality, which is why the AHA and its member hospitals work closely with the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF), and The Joint Commission and other national accreditation bodies. However, the federal agencies' disparate responsibilities within the health care system prompt them to interact with and influence the work of hospitals in very different, and occasionally conflicting, ways.

Over the past several years, CMS has greatly expanded its pay-for-performance programs in accordance with provisions of the Affordable Care Act (ACA) and fostered experiments with new types of payment systems intended to promote more integrated care across the continuum. However, as CMS seeks changes in performance and improvements in integration across the care continuum, its own programs and initiatives can impede progress. For example, CMS is promoting more integrated care through bundled payment programs, various accountable care organization models and other initiatives, but its quality reporting requirements are built along the siloed lines of its payment structures, and engaging in these new models of payment imposes another layer of quality reporting that may produce confusing and discordant measures. Additionally, changes that might be made to how a health system is organized, such as creating an integrated medical staff across hospitals in the same system, put the hospital or health system at risk of being cited for violating a Medicare Condition of Participation.

AHA View

Hospitals and health systems are working to achieve the Triple Aim – better health, better health care, and lower costs. They are integrating with other providers in a variety of ways to ensure more coordinated and patient-centered care and working to eliminate unneeded expenditures. At the same time, policy-makers need to continue to reform how they oversee, regulate and stimulate change in the health care delivery system. They need to understand how their rules, measures, and actions affect the activities of caregivers on the front line so they are not creating confusion or derailing successful improvement activities with discordant or outdated approaches to regulation. This is best achieved when there is open dialogue and opportunities for discussion among affected stakeholders.

Open discussions have been particularly effective in the ongoing work to share important and reliable quality performance data with the public. However, in too many instances, progress has been hampered by the overwhelming volume of measures hospitals are being asked to collect and report, the confusing and disparate assessments of a hospital's performance in different public report cards, and the fact that some of the data are too old or the measures are too unreliable. 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 ACA calls for developing a National Quality Strategy. The law directs the Department of Health and Human Services (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. 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 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 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 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 lacks fairness and equity.

A panel convened by the NQF recently invited public comment on its report, “Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors,” which recommends adjusting health care performance measures to account for sociodemographic factors, such as education, race/ethnicity and/or homelessness. The AHA is pleased that the recommendations recognize the importance of socioeconomic adjustment in public reporting and pay-for-performance programs. The recommendations in the report also are aligned with an AHA-supported bill, the Establishing Beneficiary Equity in the Hospital Readmission Program Act, H.R. 4188, which would require CMS to adjust hospital readmission penalties for socioeconomic factors. Such adjustment is intended to provide a more level “playing field,” and ensure that hospitals caring for the most vulnerable patients are not unfairly penalized.

The AHA’s efforts to improve quality measurement and its uses in public reporting and federal pay-for-performance programs are described in AHA’s issue paper, “Quality Reporting and Pay-for-Performance Programs.”

Conditions of Participation (CoP). Since 2011, CMS has been working to overhaul its CoPs for hospitals and critical access hospitals. This major overhaul is necessary because no major changes have been made to the CoPs since 1985, and the field has changed significantly. For example, many more patients are being treated in the ambulatory care setting than inpatient setting; new tools and treatment methods are being used, including electronic health records; there are more hospitalists, intensivists and surgeons working exclusively in hospitals or health systems, and many of them are employed by or under contract to the hospital or health system in which they work. Further, the fundamental roles of nurses, doctors, pharmacists and therapists have changed as we have learned more about how to provide team-based care.

All of these changes and more have altered the nature of hospital care and the relationship between hospitals and their medical staffs. Additionally, there is a new understanding of the tools and techniques for achieving higher quality, safer and more reliable care, a new expectation of the on-going responsibilities for patients post discharge from the hospital, and new knowledge about the vulnerabilities of our physical plants during normal operation and in the event of a disaster. CMS is striving to craft its requirements to recognize how care has changed, how requirements for buildings have evolved in response to experience and new knowledge, and to reflect new knowledge of quality and safety.

In early 2013, CMS proposed changes to the Medicare CoPs that were intended to reduce the burden on hospitals by eliminating outdated and outmoded requirements. For example, the agency proposed to rescind a CoP requirement that a member of the hospital's governing board be a member of the medical staff, and instead require periodic consultation between the governing body and the head of the medical staff. However, CMS also 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.

To ensure hospitals are prepared to deal with emergencies of all kinds, CMS also issued a proposed rule delineating emergency preparedness requirements in late 2013. The AHA urged CMS to align its proposals with existing standards from the fire marshals, the Hospital Preparedness Program and others; clarify who has the lead in emergency preparedness planning for the community and how the preparations of individual hospitals or health systems can be integrated with the plans of others serving the same communities; and improve their process for implementing these complex requirements. (Refer to the AHA issue paper, "Hospital Emergency Preparedness and Response," for more details.)

CMS also is working on revisions to the Life Safety Codes embedded in the CoPs, and recently proposed a rule delineating those changes.

The AHA applauds CMS for recognizing that its CoPs are out of date and supports many of the proposed changes; however, we remain concerned that CMS lacks a process for routinely and predictably updating the CoPs to ensure that they stay aligned with rules from other organizations overseeing the quality and safety work at hospitals. Further, we continue to work with CMS to ensure its CoPs do not impede progress toward more integrated care delivery. Since the CoPs were crafted on the premise that each hospital, as defined by having a unique CMS Certification Number (CCN), is an independent organization, efforts to be more integrated and standardized across systems have occasionally been thwarted by CMS and its surveyors insisting on strict adherence to the CoPs.

Drug Availability and Safety. Hospitals and health systems remain deeply concerned about chronic drug shortages. There were approximately 70 active drug shortages in the first quarter of 2014, including shortages of essential and broadly needed drugs, such as saline solutions. These drug shortages make delivering patient care more difficult and dangerous by causing delays in treatment and forcing the use of alternative drugs that come from sources not well regulated by the FDA or 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."

As the saline shortage worsened in early 2014, the AHA urged the FDA to improve the availability of this critical supply to hospitals and consider importing saline from trusted sources abroad. The AHA also provided expert guidance to its members, urging them to take all appropriate steps to protect the dwindling supply of saline.

The AHA has been working closely with the office of the Assistant Secretary for Emergency Preparedness, and the FDA to better understand and seek solutions for drug shortages, which create a public health crisis. After 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 an important 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.

PURSUING EXCELLENCE

Hospitals in Pursuit of 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.

HPOE, along with AHA and HRET, accelerates quality improvement in the health care field by:

- Sharing best practices through *www.hpoe.org*;
- 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.

National Improvement Projects. HRET and the AHA also are leading national improvement efforts that are changing the way hospitals provide care for patients. Through CMS's Partnership for Patients campaign and the Hospital Engagement Network (HEN) program, the AHA and HRET are assisting 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. Over the first two years of the program significant improvements in quality were made in key clinical areas:

- An 18 percent decrease in catheter-associated urinary tract infections (CAUTIs);
- A 23 percent decrease in central line blood stream infections (CLABSIs);
- A 57 percent decrease in early elective deliveries;
- A 25 percent decrease in pressure ulcers;
- A 6 percent decrease in all cause readmissions; and
- A 6 percent decrease in surgical sites infections.

Together these improvements resulted in better care for more than 69,000 patients with associated cost savings of \$202 million. Equally important, the program has helped the hospital field develop the infrastructure, expertise and organizational culture that will support further improvements for years to come. In addition to accelerating improvement nationally, patients are benefiting every day from the spread and implementation of best practices.

Beyond HEN, HRET's work through funders like AHRQ is helping the field embrace and learn best practices in patient care. In particular the use of the Comprehensive Unit-based Safety Program (CUSP) has resulted in some prominent

successes. CUSP is a customizable program that helps hospital units address the foundation of how clinical teams care for patients. It combines clinical best practices with an understanding of the science of safety, improved safety culture, creating a learning culture and an increased focus on teamwork.

On the CUSP: Stop CAUTI (www.onthecuspstophai.org) has a primary goal of reducing the CAUTI rate in hospital units participating in the project by the completion of the four-year initiative. Secondly, this project seeks to make decreased CAUTI rates sustainable by fostering a culture of safety in participating units. Since 2011, 79 percent of the units participating have reduced or maintained a rate of zero CAUTIs. The project continues to successfully expand by increasing its reach both to new geographic locations and to new areas of the health care system, as well as by broadening exposure of participating units to national experts, and does so in an inclusive manner involving hospitals of all types, including rural and urban, teaching and non-teaching. HRET also will be working to reduce CAUTIs and other health care-associated infections in long-term care facilities. The project seeks to implement CUSP in nursing homes and skilled nursing facilities nationwide.

HRET also is leading Team Strategies to Enhance Performance and Patient Safety (TeamSTEPPS), which was jointly developed by AHRQ and the Department of Defense Patient Safety Program as a system to train health care workers to function as a safe and effective team. TeamSTEPPS (www.teamsteppportal.org) improves communication and teamwork skills among health care professionals. It includes a comprehensive set of ready-to-use materials and a training curriculum to successfully integrate teamwork principles into any health care system.

In addition, AHRQ is funding a 12-month patient safety improvement collaborative (www.ascsafetyprogram.org) in which participating ambulatory surgery centers, hospital outpatient departments, endoscopy centers and primary care offices will effectively implement surgical safety checklists that integrate clinical and safety culture practices. With an aim of zero harm for patients undergoing care in ambulatory surgical settings, the goal is the reduction of surgical site infections and complications.

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 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.



Quality Reporting and Pay-for-Performance

Background

Quality measurement is at the center of a wide range of efforts to improve hospital performance, and to transform the payment system from a volume-based methodology to one that rewards value—that is, better quality at the same or lower cost. More than 10 years ago, hospitals initiated efforts to publicly report quality data in order to share important and reliable information with the communities they serve, identify opportunities to improve care and be able to track their improvements. Subsequently, this public reporting of quality measures was linked to Medicare hospital reimbursement through the Hospital Inpatient Quality Reporting Program. 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 full annual payment updates.

The Affordable Care Act (ACA) expanded quality measurement efforts by introducing new pay-for-reporting programs for inpatient psychiatric facilities, prospective payment system-exempt cancer hospitals, long-term acute care hospitals and inpatient rehabilitation facilities. The ACA also established “pay-for-performance” programs that reduce Medicare reimbursement to hospitals and physicians who score below national performance benchmarks on selected quality measures. For hospitals, some of the areas measured include readmissions, hospital-acquired conditions, mortality, patient experience of care, and clinical process measures of heart attack, heart failure and pneumonia.

AHA View

The AHA believes that well-conceived public quality reporting and pay-for-performance programs can align the health care delivery system toward continuous quality improvement. To date, however, federal quality reporting and payment programs have proliferated without strong alignment to specific, measurable national improvement objectives and goals for quality improvement. As a result, the sheer volume of measures and disparate ranking and rating efforts have become overwhelming and distracting to quality improvement efforts, with different priorities, different goals and different incentives impeding efforts to enhance coordination across the care continuum. Moreover, the AHA is concerned that certain quality measures in federal programs do not lead to better outcomes for patients or do not produce accurate performance results. Lastly, we believe the manner in which some of the payment penalties are calculated lacks fairness and equity.

To ensure federal pay-for-performance programs promote better health, better care, lower cost and greater engagement of patients in their own health care, the AHA’s efforts are focused on both strategic and program-specific issues, which are outlined in detail below.

Enhancing Alignment of Quality Measurement. At a time when health care resources are under intense scrutiny, an aligned, focused and rigorous approach to quality measurement and pay-for-performance programs can ensure that such

programs are targeted at areas that will truly drive the most meaningful improvements across the health care delivery system. Broadly defined, alignment means that measurement priority areas are the same across payment programs, and that the decision to use particular measures in a particular program is driven by a consistent set of principles. For example, a well-crafted measure of pressure ulcers may be suitable for every setting where patients are at risk. However, alignment also may mean using measures that assess different providers' responsibilities in achieving an overall desired goal. For example, if the goal is to reduce early mortality from heart disease, the Centers for Medicare & Medicaid Services (CMS) could use a series of aligned measures in which primary care clinicians are assessed on their ability to manage blood pressure and diabetes in their patient population, hospitals are assessed on their proficiency in re-perfusing the heart muscle quickly (e.g., door-to-balloon time), and cardiac rehab facilities are assessed on their ability to improve patients' ability to return to activities of normal living.

CMS should select the most accurate and reliable measures for programs so that consumers have dependable information to inform their decisions, and so providers can appropriately benchmark performance. Specifically, CMS should begin this work in collaboration with the National Priority Partnership – a body that was originally envisioned as a multi-stakeholder group that could provide important input on a small number of specific national priority areas.

The AHA has repeatedly urged CMS to use a consistent process to add measures to its quality reporting and pay-for-performance programs. Adherence to the steps outlined below would encourage the selection of the best available measures to both accurately reflect provider performance and address issues of high priority:

- Measures implemented in federal programs should be reviewed and endorsed by the National Quality Forum (NQF) prior to inclusion in a federal program to ensure that each measure is important, scientifically sound, useable and feasible to collect.
- Federal programs should require that measures being considered for inclusion be reviewed by the Measure Applications Partnership (MAP) before they are formally proposed in rulemaking.
- Before being used in a pay-for-performance program, each measure should be included in a national public reporting program for at least one year so appropriate adjustments and potential unintended consequences can be identified and addressed.
- When there is evidence of consistent and sustained excellent performance, the measure should be retired from performance-based incentive programs and public reporting programs to create room for new measures.

Inpatient Quality Reporting (IQR) Program. The IQR program requires that hospitals submit data on quality measures designated by CMS. In turn, those measures are publicly reported on the Hospital Compare website. Hospitals that fail to meet IQR reporting requirements are subject to a 2 percent reduction in their annual payment update. As part of the IQR, CMS can choose to use claims data to calculate and publicly report hospital performance, as it has for readmission and mortality measures. Currently, hospitals report 57 measures under the IQR.

Stroke is a common reason for hospital admission, and it is appropriate for CMS to want to measure and improve the quality of stroke care. Unfortunately, the two measures chosen – stroke mortality and readmission within 30 days of hospital discharge – fail to accurately reflect hospital performance. The AHA continues to urge CMS not to use these measures in any federal programs until adequate adjustments for stroke severity can be made.

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. The VBP program is budget-neutral. That is, it is funded by reducing all inpatient prospective payment system (PPS) Medicare-severity diagnosis related group (MS-DRG) payments by a certain percentage, and all the funds withheld must be paid out to hospitals. The reduction is applied to the operating base MS-DRG and does not affect indirect medical education (IME), disproportionate share hospital (DSH) or outlier payments. The payment reduction is 1.25 percent in FY 2014, and will continue to rise by 0.25 percent each year, topping out at 2 percent in FY 2017 and beyond. For FY 2014, CMS estimates that approximately \$1.1 billion will be available to redistribute to hospitals as VBP payments.

VBP measures are selected from among those used in the Medicare IQR program and must be reported in the IQR for at least one year before they are used in VBP. For FY 2014, CMS finalized 17 measures for the VBP program. This will increase to 19 measures in FY 2015. To calculate VBP payments, CMS establishes “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.

In general, the AHA favors pay-for-performance programs, such as VBP, that assess multiple aspects of care and that recognize providers for both achievement versus national benchmarks and improvement versus baseline performance. We

believe this incentive structure can provide greater inducement for providers to improve performance. **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:**

- *Outcome Measure Reliability:* 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. Beginning in FY 2014, CMS will use three 30-day mortality measures. 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.
- *HCAHPS Measures:* We believe CMS should assign a lesser weight to scores from the Hospital Consumer Assessment of Health Providers and Systems (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.

Hospital Readmission Reduction Program (HRRP). The HRRP imposes financial penalties on hospitals for “excess” readmissions when compared to “expected” levels of readmissions. The potential penalty increased to 2 percent of base payments in FY 2014 and will increase to 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 IQR. Beginning in FY 2015, CMS will add measures for chronic obstructive pulmonary disease and patients undergoing total hip or knee replacement.

America’s hospitals are committed to reducing unnecessary readmissions. However, early experience with the HRRP shows that hospitals caring for the poorest patients are disproportionately more likely to incur penalties under the program. Hospitals treating a higher proportion of poor patients fare worse in the HRRP because the current HRRP fails to recognize that community factors outside the control of the hospital – such as primary care, mental health services, physical therapy, easy access to medications and food that meets the patient’s prescribed diet, and other rehabilitative services – play a significant role in determining how likely it is that a patient’s health will continue to improve after discharge from the hospital or whether a readmission may be necessary. These community issues are reflected in readily available proxy data on socioeconomic status, such as the proportion of patients dually eligible for Medicare and Medicaid, and this data could be used to adjust penalties. The AHA strongly

urges CMS, Congress and others to incorporate into the HRRP an appropriate adjustment for socioeconomic factors so that hospitals caring for our nation's most vulnerable patients are not unfairly penalized under the HRRP.

In addition to adjusting for socioeconomic factors, the AHA continues to urge CMS to exclude readmissions unrelated to the initial reason for hospitalization, as required by the ACA. The AHA successfully advocated for a provision in the ACA 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.

Hospital-acquired Condition (HAC) Reduction Program. In August 2013, CMS released its inpatient PPS final rule implementing the HAC program's eligibility requirements, specific measures and scoring methodology. In general, HACs are adverse, potentially preventable safety events, such as central-line associated bloodstream infections, pressure ulcers and falls with serious injury. By statute, the HAC program must impose a 1 percent reduction to total inpatient MS-DRG payments (including IME, DSH and outliers) for hospitals in the top 25 percent of risk-adjusted national HAC rates beginning in FY 2015. Thus, even if an individual hospital significantly improves its performance from one year to the next, it may still be subject to a penalty. Similarly, even if the hospital field as a whole achieves strong performance, one quarter of all hospitals will still be unfairly subject to payment reductions.

The AHA has a number of concerns with the HAC program. First, the HAC measures are unnecessarily duplicative with those in the VBP program. This has the potential not only to create excessive double payment penalties, but also to lead to confusion about the true state of hospital performance. To provide short-term relief, the AHA recommends that CMS use measures in either the VBP or HAC program, but not both programs. Second, data show that hospitals treating complex patients will be disproportionately penalized under the HAC program. We continue to urge CMS to identify additional NQF-endorsed measures that address safety issues affecting as broad a range of hospitals as possible. Finally, the HAC program would use PSIs based on claims data to identify patients that have potentially experienced a safety event. We are concerned that the rates derived from the PSI measures are inexact and simply not rigorous enough for public reporting or payment penalty application as they fail to accurately and meaningfully reflect hospital performance.

America's hospitals are deeply committed to reducing preventable patient harm. However, as currently designed, the HAC Reduction Program imposes arbitrary, excessive penalties that disproportionately impact hospitals tending to care for

the sickest patients. The AHA will work with CMS, Congress and others to make improvements to the existing policy, as well as promote alternatives to the HAC program that more effectively promote patient safety.

Electronic Clinical Quality Measures (eCQMs). The movement toward adoption of electronic health records (EHRs) should facilitate the greater ease in calculation and reporting of clinical quality measures for hospitals. Hospitals are eager for real-time access to information from their EHRs to support quality improvements. With the intention of accelerating the adoption of EHR-enabled quality measurement, CMS and the Office of the National Coordinator for Health IT (ONC) require hospitals to report data on more than a dozen eCQMs as part of the Medicare EHR Incentive Program. These eCQMs assess areas such as stroke care, the prevention of venous thromboembolism and the frequency of early elective deliveries. CMS has expressed strong interest in aligning the reporting of quality data in the Medicare EHR Incentive Program with the IQR program. To that end, CMS adopted a policy in the FY 2014 inpatient PPS final rule that allows hospitals to voluntarily report one quarter of data for 16 IQR program quality measures using EHRs certified in the Medicare EHR Incentive Program, thereby receiving credit in both programs.

To date, however, CMS and ONC's efforts have not enabled EHRs to generate feasible, reliable and valid quality data for reporting purposes. Due to insufficient testing of measure specifications and data abstraction methods, the eCQMs do not provide accurate representations of hospital performance. Efforts to simply display data reported from EHRs undermines the intent of the federal public quality reporting efforts – that is, to provide consumers with reliable data on quality of care, and to enable providers to benchmark and improve their performance. In addition, a recent study commissioned by the AHA shows that efforts to capture eCQM measure data significantly adds to clinicians' workload without perceived benefit to patient care.¹

For these reasons, the AHA continues to urge CMS and ONC to slow the pace of the transition to electronic quality reporting to allow for policy and technology challenges to be addressed. Technology testing also needs to occur in order to assess the readiness of EHRs to support a safe and credible transition from chart-abstracted measures to eCQM reporting. (Refer to the AHA issue paper, "Health Information Technology," for more information.)

Physician Quality Reporting and Pay-for-Performance. Physicians and other eligible professionals (EPs) participate in CMS quality reporting and pay-for-performance programs that operate independently of hospital programs. Under the physician quality reporting system (PQRS), individual physicians and physician

¹ A summary, along with the full study, are available at <http://www.aha.org/research/policy/ecqm.shtml>

groups are required to report quality measures to earn an incentive payment or, beginning in 2015, avoid a payment penalty. The physician value-based payment modifier (VBM) ties payment to performance on PQRS measures, with physicians eligible for an upward or downward payment adjustment of 1 percent in 2015, and 2 percent in 2016. To date, the reporting requirements, measures and scoring methodology for PQRS and VBM have been completely different than those used in analogous programs for hospitals.

However, hospitals have become increasingly focused on physician quality reporting and pay-for-performance programs as physician integration efforts become more prevalent. In 2012, America's community hospitals employed approximately 233,000 physicians, including interns and residents, and that number is growing rapidly. In addition to direct employment, hospitals contract with physicians on a group or individual basis, such as emergency physicians or hospitalists. Hospitals and physicians are eager to capitalize on integration efforts to better align quality improvement goals and strategies, thereby improving care across the continuum.

To further encourage this alignment, the AHA urges CMS to allow hospital-based physicians to use their hospitals' inpatient and outpatient quality reporting measures and data to meet PQRS and VBM requirements. Using hospital-based measures would allow hospitals and affiliated physicians to be held accountable for performance on the same issues, thereby enhancing coordination and leading to improved quality and efficiency for patients.

Post-acute Care Quality Measurement. Quality reporting efforts for post-acute providers have greatly expanded in recent years. In addition to the previously existing quality reporting programs for nursing homes and home health providers, the ACA mandated quality reporting for long-term acute care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs) beginning in October 2012. In general, the AHA believes that rigorous, transparent measure reporting efforts are critically important to improving the quality, safety and value of post-acute care.

To ensure the long-term credibility of such efforts, the AHA urges CMS to select for its post-acute quality reporting programs only those measures that are specified, tested and NQF-endorsed for the care setting (e.g., LTCHs, IRFs) in which they will be used. For instance, CMS finalized a measure assessing the proportion of patients experiencing one or more major falls with injury for the long-term care hospital quality reporting (LTCHQR) program. Reducing patient falls is a critically important goal; however, the measure in the LTCHQR is specified, tested and NQF-endorsed for use in nursing homes, not LTCHs. The practice of using measures for one care setting and applying them to another without adequate specification and testing may result in measure results that do not accurately reflect provider performance.

Similarly, the AHA is concerned that the readmission measures finalized for CMS's post-acute reporting programs have not yet been NQF endorsed, and as a result, the field has limited information about their validity, reliability and usefulness in reducing readmissions. We agree that post-acute providers are critically important to reducing hospital readmissions. However, measurement efforts must be carefully structured to help, and not hinder, collaboration across the entire care continuum. Moreover, measures must be carefully risk adjusted to ensure that providers do not score poorly because of factors beyond their control, such as severity of illness, or community factors that compromise access to needed support resources. As the AHA has urged, CMS submitted the readmission measures as part of an NQF endorsement review committee on readmission measures. The AHA will carefully monitor this project and advocate that CMS use only those readmission measures that successfully attain NQF endorsement.



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Coverage

Background

For the millions of individuals without health insurance, the Affordable Care Act (ACA) holds the promise of broader access to the U.S. health care system, through either commercial insurance or expanded Medicaid. On Jan. 1, the ACA provided a gateway to coverage for many unable to afford it. The ACA includes a combination of expanded public programs and private-sector health insurance expansions, and the creation of new health insurance marketplaces, to make affordable coverage available.

Though the ACA has been through a myriad of legal, legislative, regulatory and operational challenges since it was signed into law in 2010, roughly 8 million Americans have signed up for coverage effective in 2014 through the federal and state-based marketplaces. We do not know the total number of individuals who will gain coverage through the marketplaces and Medicaid this year, but that number would likely have been higher before the 2012 Supreme Court decision that allowed each state to decide whether to expand their Medicaid programs. Hospitals play an instrumental role on the front lines of the enrollment effort. They also have implemented programs and strategies to ensure that the newly insured are able to access care when it is needed. Hospitals remain committed to providing access to health services and to connecting patients and families with available coverage options.

AHA View

Universal health care coverage is key to achieving the AHA's vision of healthy communities, where all individuals reach their highest potential for health. The AHA continues to work closely with the federal government, state hospital associations and hospitals to provide resources and tools that will help connect patients and their families with affordable coverage and access to quality care. The following are descriptions of the key components of the ACA, followed by their implications for hospitals.

KEY COMPONENTS OF THE ACA

Health Insurance Marketplaces. The ACA has changed how private insurance is bought and sold in the U.S. The most significant changes began Jan. 1, when coverage purchased on the new health insurance marketplaces became effective. All insurers must comply with reforms, such as bans on pre-existing condition exclusions and lifetime limits. For individuals who do not have an offer of qualifying and affordable coverage from their employers, the new marketplaces offer the opportunity to purchase private coverage. Individuals who purchase coverage through a federal or state-run insurance marketplace may be eligible to receive federal subsidies that make the insurance premiums and share of costs more affordable. However, many newly insured consumers, especially those that purchase low-cost plans, are anticipated to have significant cost-sharing obligations when they access care. For some hospitals, medical bad debt exposure will increase with the implementation of the ACA, but may be offset by a decline in uncompensated care and reduced cost sharing for low-income enrollees. Data on

utilization, cost share collection rates, low-income subsidy levels and Medicare and Medicaid disproportionate share hospital payment (DSH) reductions will ultimately determine the amount of increased financial risk for hospitals.

Insurance Market Reforms. The ACA requires significant insurance market reforms that are applicable to all plans, whether they are offered inside or outside the new health insurance marketplaces. These reforms include:

- *Guaranteed Issue* – Health insurers will be required to accept everyone who applies for coverage.
- *Renewability* – Health insurers will be required to guarantee the renewability of coverage regardless of health status or utilization of services.
- *Elimination of Lifetime Limits* – Insurers can no longer set lifetime or annual benefit limits on the dollar value of benefits.

For hospitals, this means that care, which was previously uncompensated because the patient was denied insurance due to a pre-existing condition or “dropped” by his or her plan upon becoming ill, will be covered. This should significantly reduce the financial burden on patients and their families, regardless of their income level.

Affordable and Comprehensive Insurance Products. The ACA requires every health plan, known as Qualified Health Plans (QHPs), to offer on the federal or state marketplaces a robust set of essential health benefits (EHBs) that cover 10 general categories. The EHBs are determined by the Health and Human Services (HHS) secretary and will be updated periodically. The QHPs are categorized based on their actuarial value into four benefit levels – bronze, silver, gold and platinum – that can be offered in the individual and group markets.

In addition to the four levels, catastrophic plans must be available to the following: 1) those aged 30 or younger; 2) those who cannot find coverage (net subsidies) for less than 8 percent of their adjusted gross income; and 3) those who meet one of the 12 hardship exemptions currently defined by the Internal Revenue Service (IRS) Code. All QHPs sold through the new marketplaces have enrollee out-of-pocket expenses capped at the level of a qualified High Deductible Health Plan as defined by the IRS. These are indexed by the IRS annually for inflation. For 2014, this limit is set at \$6,350 for individual coverage and \$12,700 for families. As a result, once the individual has paid this amount, the insurer will pay 100 percent of contracted amounts for covered services, thus capping bad debt exposure, except for uncovered services. Balance-billing for out-of-network services, the amount between the insurer’s contracted rate and the provider’s charge, paid by the enrollee do not count toward the out-of-pocket maximum.

Financial Assistance for Low-income Enrollees. There are two categories of financial assistance available under the ACA to low-income enrollees who purchase products through the marketplaces – premium credits and cost-sharing reductions that include assistance at the point of service and with total out-of-pocket costs. Premium credits reduce the monthly premium amount and are determined based on a sliding scale between 100 percent and 400 percent of the federal poverty level (FPL). Credits also are scaled by family size.

Cost-sharing reductions lower the amount that an enrollee must pay at the point of service. Cost-sharing reductions are available only to enrollees in silver plans. Individuals who select bronze plans are subject to higher cost sharing and do not benefit from the cost-sharing reductions. Cost-sharing reductions are paid directly to the QHP issuer by the government to make the issuer whole for the full cost-sharing amount under the plan. This means that the subsidized portion of cost sharing should be included in the plan's payment to providers. Providers are encouraged to review payments in light of these rules.

Individuals earning below 250 percent of the FPL and who enroll in a silver plan, are also eligible for financial assistance that lowers their out-of-pocket maximum, the amount at which they no longer owe cost sharing. Lowering out-of-pocket obligations for enrollees improves their ability to afford needed care and reduces the risk of unpaid obligations to providers.

IMPLICATIONS FOR HOSPITALS

Getting People Enrolled. Since the ACA became law in 2010, hospitals have marshaled resources and worked with community stakeholders to make available information on the coverage options and financial assistance to low-income individuals and families in their communities. To assist hospitals, the AHA has created tools and resources that can be found at www.aha.org/getenrolled. The website features resources on how to connect patients and families with coverage opportunities, including private options available through the marketplaces as well as public options available through Medicaid and the Children's Health Insurance Program (CHIP). There also is information on ACA consumer assistance programs, such as certified application counselors (CACs), that are intended to provide unbiased information to consumers about their coverage options. Hospitals and health systems can seek designation to serve as CACs once they meet certain criteria and complete training. In addition, hospitals can temporarily enroll patients in Medicaid coverage at the point of service with a few basic pieces of information such as income and household size. Known as Medicaid presumptive eligibility, this ACA provision not only aids patients in obtaining needed health coverage, but also helps hospitals receive payment for services provided before a full Medicaid determination is made.

The AHA also is collaborating with key stakeholders on the national level. 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 exchanges and Medicaid. Visit www.enrollamerica.org to learn more.

Narrow Networks. For products on the new marketplaces, many health plans have elected to offer narrow and tiered provider networks as a means of controlling medical costs. Narrow networks limit access to preferred providers, while tiered networks separate providers into preferred and non-preferred tiers (often based on cost) with different cost sharing for each tier.

Reduced Provider Payments. To address affordability issues in the new marketplaces, some health plans are negotiating with providers to accept lower payment rates. In some cases these are similar to Medicare rates. Others, in response to the administrative cost limitations of the medical loss ratio requirements, are moving more providers toward capitated payment arrangements where they shift the risk and a portion of administrative expense to the provider.

Administrative Simplification. There are administrative simplification requirements 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 standardized and coordinated process for helping low-income, uninsured patients obtain coverage will reduce administrative and uncompensated care costs for providers.

Premium Subsidies and Third-party Payment. Recognizing that an individual's share of the cost of a premium or for services received may be prohibitive, even with a federal premium subsidy, hospitals and health systems have expressed interest in providing subsidies for the purchase of premiums and cost sharing and have inquired whether there are any legal barriers to providing assistance if they wish to do so. The Centers for Medicare & Medicaid Services (CMS) recently released an interim final rule requiring issuers of QHPs "to accept premium and cost-sharing payments made on behalf of enrollees by the Ryan White HIV/AIDS Program, other Federal and State government programs that provide premium and cost-sharing support for specific individuals, and Indian tribes, tribal organizations, and urban Indian Organizations." However, the rule does not prevent QHPs from having "contractual provisions" prohibiting the acceptance of premiums and cost-sharing from third-party payers other than those specified in the regulation, and CMS continues to discourage third-party payments by hospitals, other health care providers, and other commercial entities, and encourages QHPs to reject such payments.

The AHA is extremely disappointed that CMS has failed to prohibit issuers of QHPs from rejecting premium or cost-sharing payments from hospitals or affiliated foundations on behalf of needy enrollees. The AHA is pressing for a confirming public statement from HHS officials that it is not discouraging hospital-affiliated and other charitable foundations from subsidizing premiums or cost sharing. Refer to the April 8 AHA Legal Advisory for more details on premium subsidies.

Streamline Quality Reporting and Metrics. The establishment of quality reporting requirements for health plans provides an opportunity to streamline the quality metrics and quality reporting requirements applied across health plans. The AHA, in its advocacy with CMS, has pushed for provisions to reduce the administrative burden associated with the inconsistencies across plans and programs. (Refer to the AHA issue paper, “Quality Reporting and Pay-for-Performance” for more details.)

Bad Debt Mitigation. Hospitals are encouraged to engage in coverage outreach and enrollment assistance to ensure that individuals – especially those with low incomes – are able to optimize the financial assistance programs available under the ACA. Additionally, hospitals should review the impact of the ACA’s policies on their hospital’s charity care policies so that patients and their families can understand the financial assistance programs available to them.



Health Information Technology

Background

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. At the same time, hospitals and health systems are factoring other elements of health IT into their operations, including interoperability, cybersecurity and mobile health technologies. As with any new technology, health IT safety must be considered. For hospitals and physicians, all IT implementations also must be reviewed to ensure that they support the transition to ICD-10, which was recently delayed until Oct. 1, 2015.

AHA View

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. In fiscal year (FY) 2014, all hospitals and physicians must upgrade to the 2014 Edition Certified EHR and meet higher performance requirements to qualify as meaningful users under Medicare and Medicaid. Hospitals paid under the inpatient prospective payment system face the loss of incentive payments and significant penalties if they cannot meet these requirements. Critical access hospitals also face the loss of incentives. Given the complexities of the program, and the delays in delivery of certified EHRs from vendors, the AHA, along with 47 other organizations, in late February urged the secretary of Health and Human Services (HHS) to extend through 2015 the timelines for hospitals, physicians and other eligible professionals to implement the 2014 Edition Certified EHR, and add flexibility in meaningful use requirements. With only a fraction of 2011 Edition products currently certified to 2014 Edition standards, it is clear the pace and scope of change have outstripped the ability of vendors to support providers. Hospitals are committed to implementing EHRs to support care improvements and patient engagement. They are investing capital and human resources to meet the meaningful use requirements and should be given the time needed to implement new technologies safely and effectively.

The AHA is very concerned that the fast pace and broad scope of the EHR incentive programs pose significant challenges to hospitals and physicians and will monitor progress carefully in 2014, with a particular focus on how smaller and rural facilities are faring. In addition, we will work with the federal government to ensure that any new rules, such as those that might be proposed for Stage 3 of meaningful use, are informed by field experience and carefully weigh the benefits of new requirements against the expected costs of compliance.

Supporting Physician Adoption of EHRs. The AHA is pleased that, in response to our advocacy, HHS issued a final rule that extended through 2021 the limited exception to the Stark law and the anti-kickback law safe harbor that permit hospitals to assist physicians in developing EHRs. Those protections were set to expire on Dec. 31, 2013.

Interoperability. As the adoption of EHRs spreads, hospitals and health systems are still constrained by systems that cannot efficiently share data across vendor products or departmental systems, even within an organization. Systematically sharing information across settings or organizations remains a big challenge. We expect increased interoperability that supports efficient information sharing to be a major focus of policy debate in the coming years. The AHA supports interoperability and will work to ensure that any new federal efforts to promote interoperability take into account how hospitals and physicians generate, use, share and secure health information, and the need for efficient solutions for information sharing among settings and with patients.

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 to recommend the creation of a nationally unique identifier system to connect records so 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.

The AHA is pleased that, in 2013, the Food and Drug Administration (FDA) finalized a system of unique identifiers for medical devices that will increase efficiency and add an element of transparency to the medical device industry by providing basic, standardized information on all medical devices. The unique device identifier (UDI) also will facilitate safety recalls and support improved quality of care. The AHA will work with members and FDA to ensure that the roll-out of the UDI is smooth, and encourage HHS to ensure that certified EHRs support the automated capture and use of UDI.

Cybersecurity. There is growing public and policy interest in ensuring that all information systems, not just those containing protected health information, are kept confidential and secure. In 2013, the White House issued an *Executive Order on Improving Critical Infrastructure Cybersecurity* with the goal of improving cybersecurity and reducing cyber threats to the nation's "critical infrastructure sectors," including the Healthcare and Public Health Sector, which includes hospitals. In 2014, the AHA continues to raise awareness of cybersecurity issues and risk management strategies. In particular, hospitals and health systems will want to understand the new National Institute of Standards and Technology (NIST) Framework on Cybersecurity. This framework provides a structure for organizing activities needed to manage cyber risks, such as identifying the cybersecurity risks to systems, assets, data and capabilities; taking steps to protect against

them; and detecting and responding to any attacks that may occur. Compliance with the framework is voluntary; however, the federal government will be considering incentives to promote compliance in the coming years. The AHA offers numerous tools and materials for hospitals on cybersecurity, including webinars, suggested actions for hospitals and links to resources specific to the Healthcare and Public Health Sector. Visit www.aha.org/cybersecurity.

Mobile Health (mHealth). As hospitals and health systems adopt new technologies, so do consumers. Mobile health includes use of consumer-facing applications and technologies to manage personal health and promote wellness. Increasingly, health care providers are supporting consumer use of the technologies and considering ways to incorporate mobile health data into EHRs. At the policy level, the federal government is considering whether, and how, to regulate mobile apps to ensure safety, privacy concerns and technology standards that can facilitate the efficient flow of relevant information from devices to health care providers. In fact, the FDA recently issued guidance on mobile apps, and other agencies are expected to follow suit.

Health IT Safety. The increased use of EHRs has led to an increased focus on safety issues. It is the 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 is pleased that the vendor community developed a voluntary code of conduct in 2013 that included specific commitments to ensuring and promoting safety. We will continue to push vendors for safe design and product development that will support safe use of their products. In addition, we will encourage vendors to remove from their contracts indemnity clauses or nondisclosure language that limits the ability of users to identify and raise safety concerns. Vendors also must increase transparency in pricing and adherence to existing coding conventions for systems that support billing. In 2014, we expect the federal government to produce a congressionally mandated report on health IT safety and the appropriate role of government in ensuring safety. For more information on safety issues, see the AHA's "Improving Quality and Patient Safety" issue paper.

ICD-10 Adoption. In 2009, HHS mandated adoption of new International Classification of Diseases (ICD) standards, or ICD-10. This replacement to the ICD-9 coding system was long overdue, and the AHA supports the change to ICD-10 because it provides greater precision in the classification of disease. The move to ICD-10 will mean better data to monitor resource utilization, improve clinical, financial and administrative performance and support biosurveillance of public health risks. The federal government has delayed the transition several times; most recently, Congress delayed the transition until Oct. 1, 2015.

The AHA opposes the recent one-year delay in implementation of the ICD-10 coding set. Many hospitals have incurred substantial financial obligations in implementing ICD-10, and this delay will slow down the transition to value-based payment in the health system. While the transition to ICD-10 entails significant challenges, ICD-10 will ensure payment accuracy and grow the nation's understanding of health care delivery.



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Hospital Price Transparency

Background

Over the past year, there has been considerable public and policymaker focus on the issue of health care price transparency. While public focus on this issue is not new, trends in the health care marketplace are heightening its importance. Price transparency has been a longstanding issue for uninsured patients, but growing enrollment in plans with higher levels of deductibles and coinsurance is creating a greater demand for meaningful price information for insured patients as well. Employers have been moving in this direction for a number of years. Now, newly insured individuals under the Affordable Care Act (ACA) are expected to primarily choose “bronze” and “silver” plans that include significant levels of cost sharing.

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.

AHA Position

Consumers and their families deserve helpful information about the price of their hospital care, and America’s hospitals and the AHA are committed to providing it. But more can, and should, be done to share health care information with the public, including, but not limited to, hospital pricing information. 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.

Current Initiatives. Initiatives to make charge and price data available to the public are emerging on several fronts. Currently, 42 states already report information on charges or payment rates, and make that information available to the public. Last spring, for each hospital accepting Medicare patients, the Centers for Medicare & Medicare Services (CMS) posted on its website average hospital specific charges per patient and average Medicare payments for the most common diagnosis-related groups (DRG) as well as 30 ambulatory procedures. Additionally, the ACA requires hospitals to report annually and make public a list of hospital charges for items and services, although CMS has not released guidelines to implement this provision.

The AHA recently participated in a multi-stakeholder task force to address price transparency convened by the Healthcare Financial Management Association. This task force report includes a set of principles as well as specific action steps required to achieve greater transparency. The report makes clear that achieving a more transparent system is a multi-stakeholder issue and will require consensus among hospitals, physicians and other care providers; the pharmaceutical and medical device industries; commercial and governmental payers; employers;

patients and consumer advocates; and regulatory agencies to develop a workable, meaningful solution. In April, the task force issued price transparency recommendations for health plans, health care providers and others, and a guide to help consumers estimate the cost of 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 2014 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 seven states have voluntary efforts. These state efforts range from making public information about individual hospitals' lists of prices (i.e., chargemasters), 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 (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 health insurance marketplaces in each state will provide information to the enrollee about out-of-pocket costs based on the essential health benefits that health insurers are required to include in their plan offerings. But plans can still substitute benefits as long as they are in the same category of benefits and 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 health plans, 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 advances 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, 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 for 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 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 and 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:

<http://www.aha.org/advocacy-issues/bcc/index.shtml>.



American Hospital
Association®

Hospital Field Realignment

Background

Features of the Affordable Care Act (ACA) and market trends are driving a major realignment of the health care system. To better serve their patients and communities, hospitals are strengthening ties to each other and physicians in response to new global and fixed payment schemes, incentives for improved quality and efficiency, implementation of electronic health records (EHRs), and greater coordination across the health care continuum. Much of this realignment involves mergers and acquisitions. Health plans and other consolidation critics claim hospital realignment leads to higher prices and higher premium growth. These allegations are inconsistent with data showing price growth is at historic lows.

AHA View

Increasingly, a hospital's ability to provide the care its community expects and needs, and compete in the marketplace turns on its access to capital, ability to invest in technology, and increase in operational efficiency and value. Stand-alone hospitals, especially smaller ones, are particularly vulnerable to these changing trends and may be forced to downsize their operations and services. Mergers and acquisitions are one way hospitals can adapt to these recent health care trends thereby increasing their economies of scale, building a continuum of care and improving access to capital.

Need for Capital. Hospitals are faced with unprecedented demands for capital to invest in new improvements, including EHRs, which can cost as much as \$50 million for a mid-size hospital, implementing new modes of delivering care, such as telemedicine, and building or upgrading facilities. Funding these investments requires access to significant capital. Access to traditional sources of capital, such as tax-exempt bonds, continues to be challenging for many not-for-profit hospitals. Smaller hospitals may be particularly disadvantaged if they receive lower credit ratings, which minimize their opportunities to access capital and burdens them with high interest rates. Moody's states that "[a]ccess to capital markets has become more difficult for lower-rated hospitals, driving the need for many to seek a partner."

Changes in Payment Models. Government and private payers are implementing dramatic changes to how payment for health care delivery is calculated, shifting from a fee-for-service to value-based purchasing model. The amount hospitals will be paid depends on meeting certain performance metrics, such as improved clinical outcomes, lower cost per case, information technology (IT) compliance, high patient satisfaction and lower readmission rates. Bundled payment systems also are being tested.

Coordinated care has been shown to increase clinical outcomes, but decades old regulatory barriers can prevent hospitals and doctors from working closely together in improving care and reducing costs unless they are under the same ownership umbrella. Antitrust laws, outdated fraud and abuse policies and even tax-exempt rulings favor consolidation over clinical integration.

Reductions in Reimbursement. Government reimbursement for hospitals services has been declining. Both Medicare and Medicaid, which account for more than half of hospitals' revenue, have been cut as federal and state governments look to close fiscal deficits and balance budgets. As political pressures intensify, these cuts will likely continue. Hospitals that serve low-income populations have seen cuts to Medicaid Disproportionate Share Hospital payments, which will be especially painful to the hospitals in states that do not expand Medicaid. The recent declines in inpatient stays as care shifts to outpatient settings compounds these cuts.

Benefits to Patients and Communities. Some critics claim hospital mergers and acquisitions drive up health care costs because they disadvantage large commercial insurers in contract negotiations. But the facts show that the overwhelming majority of transactions over the past six years are procompetitive. The Federal Trade Commission, which oversees most hospital transactions, consistently notes how few have been challenged for being anticompetitive.

Data from hospital mergers between 2007 and June of 2013 show that of the 607 hospital mergers and acquisitions that occurred, more than 96 percent occurred in regions with more than five other independent hospitals, providing the community with plenty of alternatives for care. The vast majority of these deals involved only one hospital. Of those that occurred in regions with fewer than four other hospitals, the majority did so in rural or mid-size regions with fewer than 200,000 people. Of these mergers, nearly 40 percent had fewer than 50 beds.

Patients receive significant benefits when caregivers work together to provide more coordinated, more efficient and higher-quality care. The numbers of transactions and the stories behind them demonstrate that mergers and acquisitions are supporting the changing landscape of health care delivery in a positive way for patients and communities by improving health and offering a long sought after alternative to an otherwise fragmented health care delivery system. To learn more, visit www.changinglandscape.org.



American Hospital
Association®

Medicare

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) 2014 will be negative 6.0 percent.

At the same time, hospitals continue to face enormous changes associated with the Affordable Care Act (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. Hospitals also are grappling with the difficult sequestration policies set forth in a series of budget bills that require a 2 percent automatic reduction to all Medicare payments through 2024. Most recently, the Protecting Access to Medicare Act (PAMA) doubled the sequester deduction to 4 percent for the first six months of 2024, while eliminating it in the last six months. Hospitals need adequate Medicare payment to ensure that patients and communities receive the care they expect and need.

AHA View

The sequester is but one 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. The AHA's 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. 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. The report is available at www.aha.org/healthiertomorrow.

Inpatient Prospective Payment System (PPS) Rule. The AHA anticipates that, in the FY 2015 inpatient PPS proposed rule, the Centers for Medicare & Medicaid Services (CMS) will continue to implement the temporary documentation and coding cuts required by the American Taxpayer Relief Act (ATRA). These cuts 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 ATRA requires that CMS recoup this difference from FYs 2010, 2011 and 2012 over a four-year period. These cuts began in FY 2014 when CMS implemented a cut of 0.8 percent (\$900 million); the agency then suggested that it would make additional cuts of 0.8 percent in each of FYs 2015, 2016 and 2017 to fulfill the ATRA requirement. Therefore, we anticipate an additional

documentation and coding cut of 0.8 percent for FY 2015. 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 flawed methodology and is overstating the effect of these documentation and coding changes.**

Disproportionate Share Hospital (DSH) Payments. Because the ACA was estimated to expand public and private health care coverage to 32 million more Americans by 2019, Congress deemed it appropriate to cut Medicare DSH payments to hospitals, reasoning that hospitals would care for fewer uninsured patients as health coverage is expanded. Specifically, the ACA reduced Medicare DSH payments by \$22.1 billion from FY 2014 through FY 2019.

CMS implemented Medicare DSH payment changes in the FY 2014 inpatient PPS final rule. The agency finalized a policy to distribute 25 percent of Medicare DSH funds in the exact manner in which Medicare DSH payments have historically been distributed – through a hospital-specific percentage add-on applied to the base MS-DRG payment rates. CMS also finalized a policy to reduce the remaining 75-percent pool by about \$546 million in FY 2014, based on the estimated percentage decline in the uninsured. The agency is distributing these funds using inpatient days of Medicaid beneficiaries plus inpatient days of Medicare SSI beneficiaries as a proxy for measuring the amount of uncompensated care hospitals provide. CMS considered instead using charity care, bad debt and other data from the hospital cost report worksheet S-10 to measure uncompensated care. However, due to concerns that the revised S-10 is relatively new and has not historically been used for payment purposes, the agency decided that its use was not appropriate at this time. The AHA will continue to work to ensure that the modifications to the Medicare DSH program are made in accordance with the DSH principles proposed by the AHA Medicare DSH Payment Advisory Committee and adopted by the AHA Board of Trustees.

In addition, although the ACA was estimated to expand public and private health care coverage to 32 million more Americans by 2019, due to the Supreme Court decision on the ACA's Medicaid expansion and the slower than projected roll out of the new insurance marketplaces, the ACA's coverage expansion will be far less than originally projected in FYs 2014 and 2015. **Therefore, in 2014, the AHA continues to work with Congress to ensure that the DSH cuts reflect this slower realization of coverage expansion. We support the DSH Reduction Act, H.R. 1920/S. 1555, which would eliminate the first two years of the ACA's cuts to the Medicare DSH program to allow expansion of health care coverage to become more fully realized.** The bills were introduced by Rep. John Lewis (D-GA) and Sen. Roger Wicker (R-MS).

Two-Midnight/Patient Status. 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 (RACs) and Medicare administrative contractors (MACs) have repeatedly second guessed physician judgment, declaring that some patients who were admitted should not have been. This has, in turn, created ambiguity over who decides what constitutes an appropriate admission and what the criteria are for making such a determination.

In an effort to clarify that ambiguity, CMS addressed the issue of patient status in the FY 2014 inpatient PPS final rule and finalized its “two-midnight” policy whereby the agency will generally consider hospital admissions spanning two midnights as appropriate for payment under the inpatient PPS. In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. CMS also implemented a 0.2 percentage point cut to inpatient payments to offset the estimated \$220 million in additional inpatient PPS expenditures it believes will be associated with this policy. The policy took effect Oct. 1, 2013, but, at AHA’s urging, CMS partially delayed its enforcement through Sept. 30, 2014. The PAMA extends the delay in enforcement of the two-midnight policy for an additional six months, through March 31, 2015. During the partial enforcement delay, CMS will not be able to conduct patient status reviews on a post-payment review basis through RACs for inpatient claims with dates of admission Oct. 1, 2013 through March 31, 2015. CMS will, however, be permitted to continue its “Probe and Educate” audits, as previously specified by the agency, through March 31, 2015.

The AHA will continue to urge CMS to fix the critical flaws of the underlying policy by engaging stakeholders to find a workable solution that addresses the reasonable and necessary inpatient-level services currently provided by hospitals to Medicare beneficiaries who are not expected to span two midnights. We anticipate that CMS may request feedback on potential policy options to address this issue in the FY 2015 inpatient PPS proposed rule.

The AHA supports the Two-Midnight Rule Delay Act/Two-Midnight Coordination and Improvement Act, H.R. 3698/S. 2082, which would implement a new payment methodology for short inpatient stays in FY 2015. The bills were introduced by Reps. Jim Gerlach (R-PA) and Joseph Crowley (D-NY), and Sens. Robert Menendez (D-NJ) and Deb Fischer (R-NE).

In addition, on April 14, the AHA, several state and metropolitan hospital associations, and four hospital systems filed two-related lawsuits against the Department of Health and Human Services (HHS) challenging CMS's two-midnight policy. The lawsuits contend that the two-midnight rule and a related

offset to Medicare payments burden hospitals with unlawful arbitrary standards and documentation requirements and deprive hospitals of proper Medicare reimbursement for caring for patients.

Area Wage Index (AWI). The AWI adjusts payments to reflect differences in labor costs across geographic areas. In February 2013, the Office of Management and Budget updated its list of Core Based Statistical Areas (CBSAs), which serve as the AWI labor markets, to reflect its new 2010 standards and 2010 census data. However, this did not leave enough time for CMS to apply these updated geographic areas to the FY 2014 wage indices. Instead, we anticipate that CMS will apply the updated CBSAs in the FY 2015 inpatient rulemaking cycle.

AWI Task Force. Hospitals repeatedly have expressed concern that the inpatient PPS AWI is greatly flawed in many respects. Congress and Medicare officials also have concerns with the current system. In July 2011, the AHA Board of Trustees created a Medicare AWI 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 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, the task force felt very strongly that there are specific actions that would categorically improve the system for the field as a whole.

The AHA board recognizes that any changes to the AWI will have various effects for all hospitals. After reviewing feedback from the field on the task force report, the AHA Board of Trustees at its July 2013 meeting declined to adopt the task force's recommendations because of a lack of consensus within the hospital field. However, the AHA board wanted to make sure that others would benefit from the thorough examination of this issue. That is why the AHA board adopted principles that will guide the AHA on proposed changes to the wage index in the future and released the draft task force report, intending to add to the public policy discussion about AWI reform similar to the release of reports by CMS, the Institute of Medicine and MedPAC.

At the same time, the AHA board supported taking certain steps related to the AWI, including:

- Advocating for the task force recommendation that CMS should designate one fiscal intermediary/MAC to complete all wage index data collection and

processing to improve the accuracy and consistency of the wage index;

- Supporting CMS's planned implementation of regulatory changes based on 2010 census data to the CBSAs that are used to delineate AWI labor markets; and
- Developing and advocating for a policy that does not allow the spread between the highest and lowest wage index values to increase – for at least three years – after these census changes are adopted in FY 2015. After three years, an evaluation of the consequences of the policy should be conducted.

Outpatient PPS Rule. The calendar year (CY) 2014 outpatient PPS final rule made sweeping changes to the payment system. These changes are important, and they also have implications for the outpatient site-neutral payment proposals being considered by Congress.

Coding and Payment. In the final rule, CMS collapsed the 10 separate evaluation and management (E/M) codes for hospital outpatient clinic visits, and replaced them with one new code representing a single level of payment for all outpatient clinic visits. The previous clinic visit codes reflecting five levels of resource intensity and the distinction between new and established patients are no longer recognized in the outpatient PPS. The adoption of a single code for all hospital outpatient clinic visits means a one-to-one coding match no longer exists to implement MedPAC's recommendation that would cap "total" payment for non-emergency department E/M services in hospital outpatient departments (HOPDs) at the rate paid to physicians for providing the services in their private offices. MedPAC has not revisited its recommendation or its impact analysis since CMS finalized the E/M code collapse policy, but had estimated that its previous policy would reduce Medicare spending by \$900 million per year and \$9 billion over 10 years, thereby reducing hospital payment between 65 percent and 80 percent for 10 of the most common outpatient services. **Given CMS's sweeping changes to the coding structure for E/M hospital outpatient clinic visit services, it is unclear how Congress could enact MedPAC's ill-advised recommendation to equalize Medicare payment rates for E/M services between HOPDs and physician office settings. Regardless, the AHA continues to strongly oppose such legislation.**

In addition, the 2014 outpatient PPS final rule identified five new categories of items and services whose costs are now packaged into the payment for other services to which they are integral, ancillary or supportive. This policy significantly increases the amount of packaging in all ambulatory payment classifications (APCs). Therefore, it will likely affect the impact estimates for the policy Congress is considering to cap "total" payment for a set of 66 groups of services furnished in HOPDs at the rate paid to physicians for providing the services in their private offices. At its January 2014 meeting, despite AHA's urging, MedPAC voted to formally recommend this policy without considering these

changes. However, based on its current analysis, MedPAC indicates that this would cut hospital outpatient payments by 2.6 percent, or \$1.1 billion, in one year. **The AHA strongly opposes legislative proposals to reduce Medicare payment rates for APCs to a residual amount of the physician payment rate or to the rate paid in ambulatory surgery centers.**

Physician Supervision. 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 (NPPs) be immediately available to furnish assistance and direction throughout the performance of the procedure. Small, rural PPS hospitals and critical access hospitals (CAHs) have expressed concern that shortages of physicians and NPPs in their communities make it difficult to comply with the direct supervision requirements.

In the 2014 outpatient PPS final rule, CMS finalized a policy to end, on Jan. 1, 2014, its prohibition on Medicare contractors enforcing the direct supervision policy for outpatient therapeutic services furnished in CAHs and in small, rural hospitals having 100 or fewer beds. For 2014, the agency, therefore, will require a minimum of direct supervision for all outpatient therapeutic services furnished in hospitals and CAHs, unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic service. **The AHA is deeply disappointed that CMS has not heeded concerns voiced by CAHs and small, rural hospitals that imposing its direct supervision policy is not only unnecessary, but will result in reduced access to care. Without adequate numbers of physicians and other health professionals in rural communities to provide direct supervision, hospitals may limit their hours of operation or close certain programs due to their inability to meet the requirements of direct supervision.**

The AHA will continue to urge Congress to provide relief from this short-sighted policy. A number of important changes that would address these concerns are included in AHA-supported legislation, the Protecting Access to Rural Therapy Services Act (S. 1143/H.R. 2801), also known as the PARTS bill, introduced by Sens. Jerry Moran, (R-KS), Jon Tester (D-MT) and John Thune (R-SD) and Reps. Kristi Noem (R-SD) and Collin Peterson (D-MN). The bill’s provisions would:

- Adopt a default standard of “general supervision” for outpatient therapeutic services.
- Develop a reasonable exceptions process with provider input to identify specific procedures that require direct supervision.
- Ensure that, for CAHs, the definition of “direct supervision” is consistent

with the CAH conditions of participation that allow a physician or NPP to present within 30 minutes of being called.

- Prohibit enforcement of CMS's retroactive reinterpretation that the "direct supervision" requirements applied to services furnished since Jan. 1, 2001.

Further, in order to give Congress more time to enact legislation like the PARTS bill, the AHA is supporting S. 1954, introduced by Sen. Jerry Moran (R-KS), and H.R. 4067, introduced by Rep. Lynn Jenkins (R-KS), that would extend through 2014 the enforcement moratorium on the outpatient therapy "direct supervision" policy for CAHs and rural PPS hospitals with 100 or fewer beds

In addition, hospitals still have an opportunity to present to the Advisory Panel on Hospital Outpatient Payment (HOP Panel) and urge it to evaluate and make recommendations to CMS on the appropriate level of supervision for 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 past input, CMS has reduced the level of supervision for 49 outpatient therapeutic services. The next HOP Panel meeting is scheduled for the summer. **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 meeting regarding additional services that could safely be downgraded to general supervision.**

Physician Payments. In 2012, America's community hospitals employed approximately 233,000 physicians, including interns and residents, and that number is growing rapidly. As physician integration efforts become more prevalent, adequate payment for professional services furnished by physicians and NPPs has become increasingly important to hospitals. The current Medicare physician payment formula is severely flawed and will result in significant payment cuts to physicians after March 31, 2015 without legislative action. The AHA will continue to work with Congress to find a permanent solution to the Medicare physician payment problem, while strongly opposing additional cuts to fund an SGR repeal that could be harmful to hospitals' ability to fulfill their mission of caring. (Refer to the AHA issue paper, "Physician Issues," for more information.)

Medicare Advantage (MA). Medicare Advantage was created as an alternative to fee-for-service Medicare. Beneficiaries can choose between traditional fee-for-service Medicare or MA plans during the annual election period, which runs from October to December, or during special election periods as deemed by CMS. MA plans must offer at least the same benefits as traditional Medicare, but they typically offer greater coverage than traditional Medicare. MA issuers are capitated by CMS for each of the beneficiaries that choose one of their plans. In addition to capitation, the MA program increases or decreases payment based on the relative risk of the issuer's covered population and offers bonuses to plans

based on their quality ratings relative to other MA plans in their market.

The MA program is the fastest growing segment of Medicare overall. More newly eligible beneficiaries are selecting plans from issuers under the managed Medicare program than choosing the traditional fee-for-service Medicare. A 2013 national study by McKinsey & Company shows that 2006-2013 compound growth for MA was 11.3 percent versus just 1.1 percent for traditional Medicare. Hospitals, therefore, are seeing a growing portion of revenue for Medicare patients coming through managed care contracts with MA issuers. These are trends that many experts believe will continue well into the future, provided that the MA program's capitated payments remain relatively stable and that MA plans continue to be offered and are affordable for most seniors. With the historical slow growth of Medicare fee-for-service costs in recent years, CMS is indicating that benchmark capitated payments will increase slightly for the 2015 plan year. Other payment and policy changes in the MA program may still result in a decline in capitation rates for MA plans. **The AHA is concerned about cuts to MA payment as those cuts impact hospitals and health systems that offer MA plans or may be passed on by issuers to providers. In addition, MA plans in recent years have reduced their networks, including hospitals, to reduce their overall medical costs and avoid premium increases or benefit reductions for beneficiaries. The AHA will continue to monitor MA trends and oppose payment offsets that would harm hospitals.**

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 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 FY 2015 budget called for reducing GME payments by \$14.6 billion over 10 years. This is a greater cut than the \$11 billion proposed last year. The FY 2015 budget also proposed \$5.23 billion to support 13,000 new residents through a new competitive GME program implemented by the Health Resources and Services Administration.

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 GME and also advocate for maintaining existing funding for GME conducted in children's hospitals.** For more information on children's hospitals GME, 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 (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 by 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 the PAMA. However, this law did not go nearly far enough in extending policies critical to rural hospitals. In 2014, we continue to work with Congress to provide small, rural hospitals with adequate reimbursement and remove the 96-hour condition of payment for CAHs.** For more information, see the AHA's issue paper, "Small or Rural Hospitals."

Post-acute care Providers. While many patients receive care in the physician's office or inpatient hospital settings, a variety of other settings are available to patients who need certain specialized follow-up care. These services, described collectively as post-acute care, support patients who require ongoing medical management, therapeutic, rehabilitative or skilled nursing care. This care is typically provided in long-term acute-care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and at home through home health agencies. For more information, see the AHA's issue paper, "Post-acute Care Providers."

Medicaid

Background

Today, nearly 70 million children, poor, disabled and elderly individuals rely on the Medicaid program for their health care. By 2022, the Medicaid program is expected to add 13 million more enrollees as a result of the expansions included in the Affordable Care Act (ACA). This is 4 million fewer Medicaid individuals 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 doors, regardless of ability to pay; however, hospitals experience severe payment shortfalls when treating Medicaid patients. In 2012, on average, hospitals were paid 89 cents for every dollar spent treating Medicaid patients, according to AHA survey data. In addition to this payment shortfall, hospitals also shouldered the burden of providing \$45.9 billion in care for the poor and uninsured for which no payment was received (uncompensated care). And while hospitals' uncompensated care burdens may partially decline as insurance coverage – both public and private – expands, Medicaid payment shortfalls will persist.

Moreover, with many state governments continuing to face budget shortfalls during a slowly recovering economy, governors and state legislatures often make Medicaid spending reductions to address looming deficits. Many governors also are seeking greater flexibility in managing their programs in order to rein in costs. In addition, cuts to federal Medicaid spending are being discussed by Congress. Some proposals being discussed would reduce spending on provider assessments, limit spending on durable medical equipment, rebase Medicaid Disproportionate Share Hospital (DSH) allotments, implement fraud and abuse initiatives and change the basic program to a per-capita-cap system.

AHA View

To meet the challenges of the future, the Medicaid program must be transformed. However, 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 initiatives, among others, to improve coverage and prevent funding cuts to these programs.

Coverage through Hospital-based Presumptive Eligibility. The ACA provides hospitals with a new opportunity to help potentially eligible Medicaid patients gain health coverage. This new opportunity, called presumptive eligibility determination, allows hospitals to temporarily enroll patients into Medicaid coverage with a few basic pieces of information, such as income and household size, at the point of service. For patients, it means they will have Medicaid coverage in the hospital, as well as after they are discharged. The AHA has been actively educating members on presumptive eligibility through tools and resources that can be found at www.aha.org/GetEnrolled.org. The AHA also has been working with our members and state hospital associations to address implementation

issues with the Centers for Medicare & Medicaid Services (CMS) regulations, such as hospitals' ability to use enrollment and eligibility service vendors to assist in presumptive eligibility determinations. At the AHA's request, in early 2014 CMS issued clarification of the eligibility service vendor issue, allowing hospitals to continue to use service vendors to assist them in making Medicaid presumptive eligibility determinations.

Medicaid DSH Payment Cuts. The Medicaid DSH payment program provides supplemental payments to hospitals that serve a disproportionate number of low-income patients. In the ACA, the DSH payment reductions were scheduled to start in FY 2014 and reflected the assumption that there would be a decrease in hospital uncompensated care as reform increased the number of patients with health insurance. However, the coverage expansions envisioned in the ACA are projected to be lower than what was expected. As a result, the AHA successfully urged Congress to delay the start of the Medicaid DSH cuts for three years, until FY 2017.

Medicaid DSH Rebasing – Extending DSH Cuts. The ACA Medicaid DSH cuts were scheduled to end in FY 2020. However, over the past few years, Congress repeatedly has extended these Medicaid DSH reductions to offset short-term legislative fixes for the Medicare physician payment formula. In fact, the Protect Medicare Access Act of 2014 extended the ACA Medicaid DSH payment reductions through FY 2024 for a savings of \$4.4 billion. **The AHA opposes using cuts to the Medicaid DSH program to pay for other Medicare spending.**

Medicaid DSH Auditing Regulation. In 2012, CMS issued 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 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 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 to be included 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 avoiding proposed provider payment cuts. Despite its importance to financing state Medicaid programs, there have been proposals, in recent years, to scale back the use of provider assessments. 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 as states work to expand Medicaid eligibility.

The AHA continues to strongly urge Congress and the administration not to restrict states' use of provider assessments.



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340B Drug Pricing Program

Background

For more than 20 years, the 340B Drug Pricing Program has provided financial relief to certain safety-net hospitals for high prescription drug costs. Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations that care for uninsured and low-income patients. Eligible health care organizations include community health centers, children's hospitals, hemophilia treatment centers, critical access hospitals (CAHs), sole community hospitals, rural referral centers (RRCs), and public and nonprofit disproportionate share hospitals that serve low-income and indigent populations.

According to the Health Resources and Services Administration (HRSA), the federal agency responsible for administering the 340B program, enrolled hospitals and other covered entities can achieve average savings of 25 to 50 percent in pharmaceutical purchases. Despite recent HRSA efforts to exert more program oversight and the program's proven record of decreasing government spending and expanding patient access to medical services, some in Congress are likely to continue their efforts to significantly reduce the benefits eligible hospitals and their patients receive from the program. HRSA is expected to issue by June 2014 a comprehensive rule that will examine several areas pertinent to the 340B program, such as the definition of patient eligibility, contract pharmacy arrangements, and mechanisms to prevent ineligible patients from receiving the benefit and duplicate discounts for Medicaid patients.

AHA View

While the 340B program accounts for only 2 percent of the \$325 billion annual drug purchases in the U.S., it provides enormous benefits to safety-net providers and the patients they serve. In fact, 340B hospitals account for 62 percent of all the uncompensated care provided in U.S. hospitals and benefit from annual drug savings of \$1.6 to \$3.2 billion per year.

The AHA believes the 340B program is essential to helping safety-net providers stretch limited resources to better serve their communities. The program creates valuable savings on outpatient drug expenditures, allowing providers to reinvest the funding in patient care and health services to benefit the communities they serve. It also saves money for state and federal governments.

The AHA opposes all efforts to scale back or significantly reduce the benefits of the 340B program. Better program oversight and clear program guidance could help 340B hospitals, but policy changes should occur with stakeholder consultation and allow for reasonable transition periods for any significant regulatory change.

The AHA supports program integrity efforts to ensure this vital program remains available to safety-net providers and encourages HRSA to develop a process to help financially distressed providers meet new program integrity provisions. HRSA has implemented several 340B program integrity measures,

including audits and annual recertification for 340B entities. HRSA also issued guidance in 2013 that disproportionate share, children's and free-standing cancer 340B hospitals are prohibited from using group purchasing organizations (GPOs) to purchase any outpatient drugs. However, these hospitals may purchase all inpatient drugs through a GPO. Based on feedback from the AHA and its 340B member hospitals, HRSA extended the implementation deadline allowing additional time for stakeholders to make the necessary changes to comply with the guidance.

The AHA supports eliminating entirely the orphan drug exclusion for certain 340B hospitals that was included in the Affordable Care Act (ACA). However, the AHA supported HRSA's approach in a July 2013 regulation implementing the ACA orphan drug exclusion provision for RRCs, CAHs and free-standing cancer hospitals. The final rule allows RRCs and CAHs to purchase orphan drugs as long as these drugs are not used to treat rare conditions or diseases, which limits the exclusion for these hospitals and provides greater access to 340B discounted drugs. The rule included several AHA-supported modifications, such as allowing hospitals subject to the exclusion to establish an alternative compliance system and permitting free-standing cancer hospitals to opt out of using the 340B program to purchase orphan drugs and instead purchase the orphan drugs through a GPO. The Pharmaceutical Research and Manufacturers of America filed a lawsuit in federal district court to stop HRSA's implementation of the orphan drug final rule. The AHA filed an amicus brief supportive of HRSA's interpretation of the orphan drug exclusion.

The AHA supports extending 340B discounts to the purchases of drugs used during inpatient hospital stays, and expanding the program to certain rural hospitals. Expansion of the program would be a "win-win" for taxpayers, as well as for hospitals. Expanding the 340B program to inpatient drugs can generate significant 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 would lower CAHs' drug costs. According to the Congressional Budget Office, expanding the program to cover inpatient services would save the federal government more than \$1.2 billion over 10 years.



Small or Rural Hospitals

Background

Approximately 46 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 small or rural hospitals. In addition, these hospitals' patient mix makes them more reliant on public programs and, thus, particularly vulnerable to Medicare and Medicaid payment cuts. Several proposals released by the Obama administration would put rural hospitals at risk of additional cuts in several areas. For example, the president's fiscal year (FY) 2015 budget outline proposes to reduce critical access hospital (CAH) payments from 101 percent to 100 percent of reasonable costs for savings of \$1.7 billion over 10 years, and to eliminate the CAH designation for hospitals that are less than 10 miles from the nearest hospital for savings of \$720 million 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, 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 – must be protected and updated.

Rural Legislation. The AHA was pleased that the Protecting Access to Medicare Act of 2014 (PAMA) contained several provisions important to rural hospitals and their patients, including one-year extensions through March 31, 2015, for the following:

- Low-volume hospital payment adjustment;
- MDH program;
- Ambulance add-on payments; and
- Outpatient therapy caps exception process (although we strongly oppose the continued expansion of the cap to therapy services provided in the outpatient departments of hospitals and CAHs.)

However, we are disappointed that the PAMA did not include provisions to suspend the direct supervision policy for outpatient therapeutic services or remove the 96-hour physician certification requirement for CAHs.

Direct Supervision. For the past several years, the Centers for Medicare & Medicaid Services (CMS) has modified its policies related to the agency's "direct supervision" requirement of outpatient therapeutic services. As of Jan. 1, CMS removed its prohibition on Medicare contractors enforcing the direct

supervision policy for outpatient therapeutic services furnished in CAHs and in small rural hospitals having 100 or fewer beds. Therefore, for 2014 and beyond, the agency will require a minimum of direct supervision for all outpatient therapeutic services furnished in hospitals and CAHs, unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic service.

The AHA is deeply disappointed that CMS has not heeded the concerns voiced by CAHs and small rural hospitals that imposing its direct supervision policy is not only unnecessary, but will result in reduced access to care. Without adequate numbers of physicians and other health professionals in rural communities to provide direct supervision, hospitals will have no choice but to limit their hours of operation or close certain programs due to their inability to meet the requirements of direct supervision.

Hospitals still have opportunities to present to the Advisory Panel on Hospital Outpatient Payment (HOP Panel) and urge it to evaluate and make recommendations to CMS on the appropriate level of supervision for 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 past input, CMS has reduced the level of supervision for 49 outpatient therapeutic services. The next HOP Panel meeting is scheduled for the summer. 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 meeting regarding additional services that could safely be downgraded to general supervision.

For more information, see the AHA's "Medicare" issue paper.

96-hour Rule. CMS has recently indicated that it will begin enforcing a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. If enforced, CAHs would be forced to eliminate these "96-hour plus" services, and the resulting financial pressure on CAHs would severely affect their ability to operate and care for beneficiaries in rural communities. **The AHA supports the Critical Access Hospital Relief Act of 2014, S. 2037/H.R. 3991, which would remove the 96-hour piece of the physician certification requirement as a condition of payment.** CAHs would still be required to satisfy the other physician certification requirements and the condition of participation requiring a 96-hour annual average length of stay. This bipartisan bill is cosponsored by Sens. Pat Roberts (R-KS) and Jon Tester (D-MT) and Reps. Adrian Smith (R-NE), Greg Walden (R-OR), Lynn Jenkins (R-KS) and David Loebsack (D-IA).

The AHA also continues to advocate before Congress for these critical programs and provisions:

- 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 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;
- Exempt CAHs from the cap on outpatient therapy 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. For more information, see the AHA's "340B Drug Discount Program" issue paper.

Electronic Health Records (EHRs) and Meaningful Use. Hospitals continue to struggle with the complex meaningful use rules, which include a requirement that all hospitals and physicians upgrade to the 2014 Edition Certified EHR this year, regardless of stage. Hospitals in both Stage 1 and Stage 2 also will face a higher bar to meet the performance metrics. For hospitals paid under the inpatient 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, so the FY 2015 penalties would be based on FY 2015 performance.

The AHA has advocated that the Department of Health and Human Services (HHS) extend the regulatory timelines for 2014 and allow all providers greater flexibility in Stage 2. Specifically, all hospitals and physicians should have the option to make the transition to the 2014 Edition Certified EHR and the Stage 2 requirements (or the revised Stage 1 requirements, as applicable) over the course of 2014 or 2015 and be given at least three years at each stage. Hospitals are reliant on their vendor partners to deliver certified EHR technology, and are facing challenges obtaining and installing certified EHRs that work as promised, making the current timelines unrealistic. For rural hospitals, one of the two major vendors had not yet certified a product as of April 1, 2014.

The AHA continues to be concerned about the impact of the EHR Incentive Program on small and rural providers; we believe that the program should close, not widen, the existing digital divide. Data from CMS suggest that CAHs, in particular, are less likely to have successfully attested to meaningful use than their urban counterparts. 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. For more information, see the AHA's "Health Information Technology" issue paper.



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Post-acute Care Providers

Background

Many patients receiving care in the inpatient hospital setting require specialized follow-up care by a post-acute care provider. Post-acute care covers a wide range of services that facilitate continued recovery with a focus on restoring medical and functional capacity to enable the patient to return to the community and preventing further medical deterioration. Post-acute care settings include long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and home health agencies.

AHA View

The AHA supports enhanced coordination between general acute-care hospitals and post-acute providers to improve overall quality of care and reduce total health spending. We continue to urge policymakers to protect access to medically necessary post-acute services and recognize the important role of post-acute care.

Long-term Care Hospitals (LTCHs). Following several years of strong advocacy by the AHA, new LTCH patient admission criteria were authorized by the Bipartisan Budget Act of 2013. These new criteria will bring substantial change to the LTCH field when implementation begins in October 2015, including lower site-neutral payments for approximately half of the current LTCH patient population. The new criteria will be phased in over a two-year period. While these new admissions standards are more stringent than what the AHA proposed and will present a challenge to the field, overall they bring clarity to the role of LTCHs relative to other hospitals and post-acute providers, provide LTCHs with a bridge to future delivery system reforms and, importantly, these standards are far less severe than the LTCH criteria that were under development by the Centers for Medicare & Medicaid Services (CMS). In addition, the AHA is pleased that the Bipartisan Budget Act also provides substantial 25% Rule relief for cost reporting periods beginning October 2013 through September 2017. The AHA and our member LTCHs have now pivoted to the analysis and planning needed to prepare for implementation of the new criteria. In addition, Congress passed a number of further changes to the LTCH provisions. In 2014, the AHA will engage in outreach to Congress and the regulatory agencies about adjustments to the criteria, which are needed to make the new guidelines more balanced.

Inpatient Rehabilitation Facilities (IRFs). 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 relatively stable Medicare IRF payments and a dramatic drop in overall volume of IRF cases. In fact, 122,000 fewer cases were treated in IRFs in 2011 than 2004. IRFs produce more positive clinical outcomes than other post-acute settings, such as higher rates of discharge to the community. IRFs continue to be targeted for savings through proposals such as site-neutral payment for IRFs and 60% Rule change. Thus, the AHA continues to oppose any proposals to raise the 60% Rule threshold or to pay skilled-nursing rates for hospital-level

IRF care. Access to IRF services must be ensured for beneficiaries who clinically require hospital-level care *and* intensive rehabilitation, such as brain injury, spinal cord injury and stroke patients.

Post-acute Bundle. The AHA supports bundled payment, including a post-acute bundle, but much work is needed to ensure that bundling is workable for patients and providers. A combination of AHA's general acute-care hospital and post-acute members are currently engaged in testing bundling approaches through initiatives with Medicare and private payers. In 2014, the AHA will host an educational series on potential partnerships between general acute-care hospitals and post-acute providers.

Post-acute Care Quality Measurement. Quality reporting efforts for post-acute providers have greatly expanded in recent years. Congressional committees are currently working on legislation to address a number of issues related to post-acute quality and resource measures and assessment data. In addition to the previously existing quality reporting programs for nursing homes and home health providers, the Affordable Care Act mandated quality reporting for LTCHs and IRFs beginning in October 2012. In general, the AHA believes that rigorous, transparent measure reporting efforts are critically important to improving the quality, safety and value of post-acute care.

To ensure the long-term credibility of such efforts, the AHA will continue to urge CMS to select only post-acute quality measures that are specified, tested, and endorsed by the National Quality Forum (NQF) for the care setting (e.g., LTCHs, IRFs) in which they will be used. Selecting such measures provides assurance that a measure can be feasibly collected by providers, and that the measure results accurately reflect provider performance. To date, unfortunately, CMS has included measures in post-acute quality reporting programs that do not meet these standards. For instance, CMS finalized a measure assessing the proportion of patients experiencing one or more major falls with injury for the LTCH Quality Reporting (LTCHQR) program. Reducing patient falls is a critically important goal; however, the measure in the LTCHQR is specified, tested and endorsed by the NQF for use in nursing homes, not LTCHs. The practice of developing measures for one care setting and applying them to another *without* adequate specification and testing compromises the accuracy and credibility of results, making it difficult to determine whether improvements are being realized.

The AHA believes that post-acute providers are critically important to reducing hospital readmissions. And we have weighed in as CMS has added readmission measures to the quality reporting programs for LTCHs, home health agencies, and IRFs, with reporting beginning during calendar year 2014. Our primary concern is that the readmission measures finalized for CMS's post-acute reporting programs have not yet been NQF-endorsed, and as a result, the field has limited

information about their validity, reliability and usefulness in reducing unnecessary readmissions. Moreover, these measures lack adequate risk adjustment to ensure that providers do not score poorly because of factors beyond their control, such as severity of illness, or community factors that compromise access to needed support resources. As the AHA has urged, CMS intends to submit readmission measures as part of an upcoming NQF endorsement review committee on readmission measures. The AHA will carefully monitor this project and advocate that CMS use only those readmission measures that successfully attain NQF endorsement to help ensure that measurement efforts are carefully structured to help, and not hinder, collaborations across the entire care continuum to prevent unnecessary hospital readmissions.

Physician Issues

Background

The Affordable Care Act (ACA) provides strong incentives to increase collaboration between physicians and hospitals to deliver high-quality, efficient care. Success in value-based purchasing, reducing readmissions and managing costs within a bundle or per capita rate requires involving physicians as full partners in examining and redesigning care processes. In 2012, America's community hospitals employed approximately 233,000 physicians, including interns and residents, and that number is growing rapidly. Strong leadership teams and physician-hospital partnerships are needed to guide the complex changes already set in motion. As such, the AHA works on several physician issues that affect hospitals.

AHA View

Physician Payment. The recently passed Protecting Access to Medicare Act of 2014 halts a projected 23.7 percent cut in Medicare physician payments by providing physicians and non-physician practitioners paid under the Medicare Physician Fee Schedule a 0.5 percent update through Dec. 31, 2014 and a 0 percent update from Jan. 1, 2015, through March 31, 2015. On April 1, 2015, physicians will once again face a significant decline in Medicare payments due to the flawed sustainable growth rate (SGR) formula.

While congressional leaders agreed on policies to permanently fix the SGR formula – outlined in the SGR Repeal and Medicare Provider Payment Modernization Act of 2014 (H.R. 4015/S. 2000) – no agreement has been reached on how to pay for the legislation's significant cost. The legislation would permanently repeal the SGR and implement a performance-based payment system beginning in 2018. HR. 4015/S. 2000 would consolidate the current law Physician Quality Reporting System (PQRS), meaningful use program and physician value-based payment modifier (VBM) and eliminate the penalties associated with those programs. In addition, physicians would be incentivized to participate in alternative payment models, such as the Medicare Shared Savings Program.

The AHA will continue to work with Congress to find a permanent solution to the Medicare physician payment problem, while strongly opposing hospital payment reductions to pay for the SGR fix.

Physician Quality Reporting and Pay-for-Performance. Under the PQRS in current law, individual physicians and physician groups are required to report quality measures to earn an incentive payment or, beginning in 2015, avoid a payment penalty. Performance on these PQRS measures are then tied to payment through the VBM, with physicians eligible for an upward or downward payment adjustment of up to 1 percent in 2015 and up to 2 percent in 2016.

Hospitals have focused increasingly on physician quality reporting and pay-for-performance programs as integration efforts become more prevalent. In addition to direct employment, hospitals contract with physicians on a group or individual basis, such as emergency physicians or hospitalists. Physicians and hospitals are eager to build on integration efforts to better align quality improvement goals

and strategies, thereby improving care across the continuum. However, concerns exist that, to date, the reporting requirements, measures and scoring methodology for PQRS and VBM have been completely different than those used in analogous reporting and pay-for-performance programs for hospitals (e.g., the Inpatient Quality Reporting Program and the value-based purchasing program).

To further encourage alignment of quality improvement goals and strategies between physicians and hospitals, the AHA will continue to urge the Centers for Medicare & Medicaid Services (CMS) to allow hospital-based physicians to use their hospitals' inpatient and outpatient quality reporting measures and data to meet PQRS and VBM requirements. Using hospital-based measures would allow hospitals and affiliated physicians to be held accountable for performance on the same issues, thereby enhancing coordination and leading to improved quality and efficiency for patients.

Electronic Health Records. While the physician community is moving forward with adoption of electronic health records (EHRs), like hospitals, they have encountered a number of challenges due to complicated and confusing regulations. While the number of eligible professionals (EPs) who are participating in the EHR incentive program has increased over the past year, the total number of participating EPs remains low overall. Efforts to allow physicians to submit quality reports to PQRS, the Comprehensive Primary Care Initiative and EHR incentive programs present overlapping and often conflicting reporting requirements leading to compliance confusion for EPs. To date, efforts by CMS and the Office of the National Coordinator for Health Information Technology (ONC) have not enabled EHRs to generate feasible, reliable and valid quality data necessary for clinical quality reporting purposes; nor do EHR data provide accurate representations of physician performance. In addition, capturing electronic clinical quality measures (eCQM) data is significantly adding to clinicians' workload without perceived benefit to patient care. The current scale and pace required to adopt the meaningful use requirements that begin in 2014 for physicians ask for too much, too soon.

In late February, the AHA, along with 47 other organizations, urged the secretary of Health and Human Services (HHS) to extend through 2015 the timelines for hospitals, physicians and other EPs to implement 2014 Edition Certified EHRs and add flexibility in meaningful use requirements. The AHA continues to urge CMS to remove the overlap and conflict in reporting requirements. (Refer to the AHA issue paper, "Health Information Technology," for more information.)

Supporting Physician Adoption of EHRs. The AHA is pleased that, in response to our advocacy, HHS issued a final rule that extended through 2021 the limited exception to the Stark law and the anti-kickback law safe harbor that permits hospitals to assist physicians in developing EHRs. Those protections were set to expire on Dec. 31, 2013.

Physician Leadership Forum. An essential element to transforming America's health care is a strong collaborative relationship between physicians and hospitals. The AHA's Physician Leadership Forum (PLF) provides an avenue for physician-hospital collaboration to advance excellence in patient care. Through the PLF, the AHA works closely with the medical community to identify critical issues and solutions to improve the performance of physicians and hospitals, including value-based care delivery, adoption of physician competencies and development of new models of care delivery. The PLF shares learning and thought leadership through educational offerings, publications and other resources. In addition, the PLF partners with physician-based associations to improve physician development and leadership training. The AHA's Committee on Clinical Leadership offers a unique opportunity for a clinical perspective to be included in the AHA policy and advocacy development process. To learn more, visit www.ahaphysicianforum.org.



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Annual Appropriations

Background

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 for 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) 2014, which began Oct. 1, 2013. Rather, after a 16-day government shutdown, Congress passed a short-term continuing resolution that kept the government funded through Jan. 15 at FY 2013 levels. Just prior to the January deadline, lawmakers passed a large omnibus bill to fund government programs for the rest of the fiscal year. The bill also set general spending levels for FY 2015.

President Obama's budget proposal, released in early March, set a recommended framework for spending, taxation and other fiscal items for FY 2015. For programs under the jurisdiction of HHS, the president proposes \$77.1 billion for health care programs, a reduction of \$1.3 billion from FY 2014.

AHA View

The AHA will urge lawmakers to approve a FY 2015 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 Graduate Medical Education (CHGME). The 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, freestanding children's hospitals train more than 49 percent of general pediatricians, 51 percent of all pediatric specialists and the majority of pediatric researchers, and do not receive GME funding from Medicare.

The AHA is pleased that Congress passed the Children's Hospital GME Support Reauthorization Act, S. 1557, which reauthorizes the CHGME program through FY 2018.

Health Professions Education and Workforce Challenges. As our nation moves toward transforming the 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 “baby boomers” begin to retire and 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, 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 for communities, hospitals are pivotal to disaster-response activities, whether they are rural, critical access hospitals or Level 1 trauma centers in major urban areas.

The Hospital Preparedness Program (HPP), the primary federal funding program for hospital emergency preparedness, has provided critical resources since 2002 to improve health care surge capacity and hospital preparedness for a wide range of emergencies. HPP funding has been a catalyst for improvements in hospital preparedness for the past 12 years, with hospitals and health systems often supplementing HPP funds with additional initiatives, coordination, training and other support. The program has led to improvements in state and local infrastructures that help hospitals and health systems prepare for public health emergencies. These investments have contributed to saving lives during many events, such as the Joplin tornado and the Boston Marathon bombing.

However, authorized funding levels and annual appropriations for the HPP have significantly declined since the program began. Congressionally authorized funding and appropriations for the HPP was \$515 million per year in the early years of the program. The Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA) reduced authorized appropriations for the HPP to \$374.7 million per year for FYs 2014 through 2018. Congress reduced HPP appropriations to \$255 million for fiscal year (FY) 2014 – a more than 50 percent reduction over the past 12 years. Similarly, the president’s FY 2015 budget proposal recommends only \$255 million for HPP.

To help hospitals and health systems develop, update and sustain their emergency preparedness and response capabilities, the AHA urges Congress to increase the FY 2015 appropriation for the HPP to \$374.7 million, consistent with the amount authorized in PAHPRA.

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. For more information, see the AHA issue paper, “Hospital Emergency Preparedness and Response.”

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 develop new and better diagnostics, preventive strategies to avoid chronic illnesses, and more effective treatments for a wide variety of diseases. The sequester had resulted in a cut of more than 5.1 percent to the NIH, which stymied important research projects. The AHA supports increased investment in the NIH and its valuable programs.

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 Affordable Care Act (ACA) greatly increases the demand for caregivers, especially primary care physicians and nurses. The law extends coverage to millions of 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 put in place 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 – workplace environment, workforce supply and employee relations.

Workplace Environment. Creating and maintaining an excellent work environment that supports the workforce and their ability to deliver high-quality care is essential. The AHA takes a multi-pronged approach to address workforce issues for America's hospitals:

- **Deploy a competent and engaged workforce.** One of the key areas the AHA has addressed is how to build 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 increased demand for primary care services. The AHA's 2013 white paper, "Workforce Roles in a Redesigned Primary Care Model," makes recommendations for redefining the health care workforce to better provide primary care services.
- **Create excellence in clinical work environments.** To aid member hospitals in examining their workforce and work environment, the AHA offers two assessments. Produced by AHA's affiliate, the American Organization of Nurse Executives (AONE), the Workplace Environment Assessment assists nurse leaders and staff to examine nine critical elements of a work environment and use the assessment as a basis for discussion of their successes and challenges. AONE and the American Society of Healthcare Human Resources Administration (ASHHRA), another AHA affiliate, collaborated on developing the Workforce Planning Model Assessment, which allows hospital leaders to examine data and strategies around hiring and retention practices, and assist in future planning and consistent evaluation of hospital hiring practices.
- **Redesign clinical care at the bedside.** The AHA's white paper, "Reconfiguring the Bedside Care Team of the Future," explains the need for a paradigm shift in the models of care hospitals are using to care for patients. The paper offers six guiding principles with foundational and cutting-edge practices that hospitals can use to assess and redesign their bedside workforce.

Workforce Supply. 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. To help hospitals sustain, grow and enhance the health care workforce, the AHA together with AONE and ASHHRA, launched the AHA Workforce Center, www.aha.org/workforce, 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.

Furthermore, the AHA is leading a new effort this year as part of the White House Joining Forces initiative on hiring veterans. We are convening an advisory group with representatives from a variety of health care organizations to identify best practices for hospitals in hiring veterans and how to enable hospitals to become employers of choice for veterans. The AHA is working closely with the Health Resources and Services Administration, the departments of Labor and Defense, and the Veterans Administration.

In addition, the AHA continues to advocate for the highest level of appropriations for nursing and allied health education programs. Although the sequester cuts to Title VIII Nursing Education programs were less than other non-defense discretionary programs, any additional cuts would be problematic. The demand for nurses will only increase as more people seek health care services as the result of new coverage through the ACA. However, meeting that demand remains difficult due to nursing faculty shortages and reduced funds for nursing scholarships and loans. The situation is compounded by the aging of the nursing workforce and the increased care burden of patients with multiple co-morbidities in a system that is facing mandatory Medicare cuts.

The ACA has helped modernize and expand Title VIII programs. Under the sections of the Workforce Development Programs, the authorization level for discretionary funding was raised to \$338 million, although the current fiscal year 2014 appropriated funding of \$223 million falls short of the authorized level in the ACA.

Visas. The AHA supports streamlining and improving the immigration process to allow qualified, internationally educated nurses, physicians and allied health professionals to work in the U.S. 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.

The AHA supports the Resident Physician Shortage Reduction Act, 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 by at least 15,000 new resident positions, 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 2014, labor and employment activities will continue to be concentrated in various regulatory agencies and the courts. Below is a snapshot of issues the AHA continues to monitor.

National Labor Relations Board (NLRB). In February, the NLRB reissued a 2011 proposed rule that would change the process for filing and processing petitions for union representation of employees, essentially speeding up the time between filing a petition and holding an election. Like the previous proposed rule, the reissued proposal would defer resolution of most voter eligibility questions until after the election, consolidate all election-related appeals into a single post-election process, and make board review of post-election decisions discretionary rather than mandatory, among other changes.

The AHA, ASHHRA and AONE had urged the NLRB to abandon the previously proposed rule in its entirety; we believe the board's decision to reissue the proposal unchanged reflects a failure by the current NLRB to give thoughtful and thorough consideration to the significant concerns raised about the original proposals by numerous organizations representing the employer community. After portions of the earlier rule were finalized, a federal district court ruled that the NLRB lacked the statutorily required quorum when it adopted the final rule. The AHA and its personal membership affiliate organizations supported the previous legal challenge to the final rule in a friend-of-the-court brief.

In addition, the AHA supports two bills that would ensure certain protections in the union election process. The Workforce Democracy and Fairness Act, H.R. 4320, introduced by Rep. John Kline (R-MN), would prohibit elections from being held sooner than 35 days after an election petition is filed; give employers at least 14 days to prepare their case to present before an NLRB election officer; and reassert the board's responsibility to address critical issues before a union is allowed to represent workers. The bill also includes an amendment offered by Rep. Tom Price (R-GA) that would restore the traditional standard for determining

the unit of workers to be included in the union. The Employee Privacy Protection Act, H.R. 4321, introduced by Rep. Phil Roe (R-TN), would give employers seven days after the NLRB determines an appropriate bargaining unit to provide a list of employees eligible to vote in the election and allow employees to choose what contact information is disclosed.

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 plans to 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. The agency asserts that hospitals' participation in managed care networks offered through TRICARE, the Federal Employees Health Benefit Program and even Medicare Parts C and D effectively makes them 'federal subcontractors' and, thus, subject to OFCCP's burdensome regulatory scheme. OFCCP has continued to pursue this policy despite Congress' previous passage of language in the National Defense Authorization Act for Fiscal Year 2012 that specifically exempted TRICARE network providers from federal contractor status.

That's why the AHA supports the Protecting Health Care Providers from Increased Administrative Burdens Act, H.R. 3633, which would prevent OFCCP from exerting jurisdiction over hospitals and other health care organizations that provide care for uniformed service members and other federal employees.



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Hospital Emergency Preparedness and Response

Background

Hospitals play a key role in the nation's emergency preparedness and response as part of America's health care infrastructure. 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. In the past two years alone, hospitals in New York, New Jersey, Massachusetts, Oklahoma, Texas and many other locations have activated their emergency plans to save lives and care for the seriously injured during disaster situations.

Emergency preparedness requires a significant investment in staff and resources. It requires constant staffing of the emergency department, laboratories, the radiology department, pharmacy, surgical services, general and intensive care units, labor and delivery and other areas. Many Americans still lack health care coverage, increasing the likelihood they will delay seeking care until it is an emergency. But hospitals must care for all patients who seek emergency care, regardless of their ability to pay. This means that it costs far more for hospitals to provide services than other settings of care.

In times of disaster, communities look to hospitals not only to care for the ill and injured, but also to provide food and shelter and help coordinate recovery. Being ready for any possible scenario, including natural disasters, biological warfare, terrorism and radiological and nuclear events, means hospitals must invest in communications and emergency power systems, purchase personal protective gear, build decontamination units and stockpile medical supplies. Hospitals must be part of comprehensive community disaster plans, training, drills and surveillance systems. These are formidable investments at a time when government funding for these services is being reduced. But it is this level of constant readiness and responsiveness that defines hospitals and benefits communities.

AHA View

Preparedness is not a one-time investment. Rather, it is a dynamic process that changes over time. Hospitals and health systems learn from each emergency situation, and it is crucial that they have the appropriate funding to adopt best practices, incorporate new technology into their emergency readiness plans and have the ability to care for their communities when a disaster or terrorist attack occurs. Greater public expectations about hospitals' role in disaster preparedness and response also have led to increased federal, state and local oversight and regulation, and more comprehensive accreditation and other standards, all of which increase the costs of preparedness.

Sustained Funding for Hospital Preparedness. The Hospital Preparedness Program (HPP), the primary federal funding program for hospital emergency preparedness, has provided critical resources since 2002 to improve health care surge capacity and hospital preparedness for a wide range of emergencies. The HPP has supported greatly enhanced planning and response, facilitated the integration of public and private sector medical planning to increase the preparedness, response and surge capacity of hospitals, and has led to improvements in

state and local infrastructures that help hospitals and health systems prepare for public health emergencies. These investments have contributed to saving lives during many events, such as the Joplin tornado and the Boston Marathon bombing.

However, authorized funding levels and annual appropriations for the HPP have significantly declined since the program began. Congressionally authorized funding and appropriations for the HPP was \$515 million per year in the early years of the program. The Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA) reduced authorized funding for the HPP to \$374.7 million per year for fiscal years (FYs) 2014 through 2018. However, for FY 2014, Congress appropriated only \$255 million for the HPP – that’s more than a 50 percent reduction from prior years. Similarly, the president’s FY 2015 budget proposal recommends only \$255 million for the HPP.

While the HPP funding is not the only way in which hospitals cover the costs of providing 24/7 emergency coverage and building the infrastructure needed to be ready for disasters, the cuts symbolize erosion in financial support for disaster preparedness at a time when the need for these services is growing. In addition, the HPP funding cuts undermine the Department of Health and Human Services’ (HHS) ambitious emergency preparedness agenda to advance all-hazards preparedness and national health security by building an effective medical surge response through the development of robust, hospital-based systems and strong, resilient and effective regional health care coalitions. This development will be difficult to achieve if HPP funding is reduced.

To help hospitals and health systems develop, update and sustain their emergency preparedness and response capabilities, the AHA urges the Obama administration and Congress to increase the FY 2015 appropriation for the HPP to \$374.7 million, consistent with the amount authorized in PAHPRA.

CMS Proposed Emergency Preparedness Rule. The Centers for Medicare & Medicaid Services (CMS) in December 2013 issued a proposed rule that would establish emergency preparedness conditions of participation (CoPs) that hospitals, CAHs and 15 other provider and supplier groups would have to meet to participate in the Medicare and Medicaid programs. CMS has formulated its proposed regulations in four key areas: risk assessment and planning based on an “all hazards” approach; policies and procedures based on risk assessment and planning; a communications plan; and training and testing. In addition, inpatient providers, including hospitals, long-term care facilities and CAHs, would be required to comply with emergency and standby power systems’ requirements.

The AHA supports CMS’s goal for Medicare providers and suppliers to have comprehensive emergency preparedness plans and generally believes that the agency has chosen the correct framework for the proposed CoPs. In the AHA’s formal comments, we urge CMS to make sure its requirements enhance readiness

without adding confusion or creating additional administrative burden. The top priority of hospitals during a disaster is to ensure that patients are safe and can receive the services they need. This is why many hospitals already meet existing emergency operations standards promulgated by The Joint Commission (TJC), National Fire Protection Association and the HPP, as well as state and local governments.

Therefore, we encourage CMS to consider five principles, detailed below, as it finalizes its proposed rule and develops interpretive guidance for the new regulations.

1. **Align policies with existing and current standards** – CMS standards should be aligned as much as possible with existing standards, laws and regulations to avoid conflict and confusion, and the standards should be evaluated and updated periodically to reflect new knowledge and advances in technology.
2. **Define leadership roles for community planning** – CMS should recognize that local emergency management and public health authorities are the best-placed entities to coordinate their communities' disaster preparedness and response, collaborating with hospitals as instrumental partners in this effort.
3. **Accept an integrated approach to emergency planning** – Integrated health systems should have the option to maintain one coordinated emergency plan in cases when a single plan improves preparedness.
4. **Collaborate to develop interpretive guidance** – CMS should use a transparent process working with stakeholders to develop interpretive guidance.
5. **Balance implementation and compliance with education** – State surveyors should assess compliance as appropriate and also realize that they can play an important educational role in helping providers meet and exceed the standards.

The AHA also is concerned that CMS has underestimated the cost and time needed to implement its proposed changes. CMS should revise the cost estimates and adjust the final rule provisions and timetables as appropriate to reflect the time and resources required.

Further, the AHA believes that the agency's proposed one-year timeframe will likely be too short for many hospitals, other providers and suppliers to come into compliance once the final rule is issued. For TJC-accredited hospitals, we believe that two years should be sufficient. In cases in which hospitals must make significant structural changes, however, the affected hospitals should be able to articulate to CMS a reasonable period of time to comply. Other providers and suppliers, including CAHs, home health agencies and hospices, also may need additional time.



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Hospital Tax Exemption

Background

Reforming the nation's federal tax code is a high priority for both President Obama and congressional leaders. President's Obama fiscal year (FY) 2015 budget proposed capping the value of the tax exemption for municipal bond interest at 28 percent. Once again, he proposed an America Fast Forward Bond (AFF) program, which would build on the Build America Bond (BAB) program. AFF bonds would be direct-pay bonds with a 28 percent subsidy rate that could be used for the same kinds of projects financed by BABs but also for projects that could be financed with tax-exempt hospital bonds. The Senate Finance and House Ways and Means Committees have held more than 50 hearings combined, examining every aspect of tax reform.

In February, Rep. Dave Camp (R-MI), chairman of the House Ways and Means Committee, unveiled comprehensive draft legislation to overhaul the nation's tax code. The draft is the product of more than 30 separate congressional hearings and 11 separate bipartisan tax reform working groups over the past three years. Under Camp's proposal the tax exemption for interest on tax-exempt 501(c)(3) hospital bonds would be repealed and advance refundings eliminated, effective for bonds issued after 2014. Investors would have to pay taxes on bond income, which would have a dramatic effect on the cost and attractiveness of hospital bonds. In addition, an individual's charitable contributions could be deducted only to the extent they exceed 2 percent of the individual's adjusted gross income. The income-based percentage limit for certain charitable contributions to public charities and certain other organizations would be reduced from 50 percent to 40 percent. Charitable contributions are excluded from the definition of income subject to the 10 percent surtax on high income individuals. While the bill is unlikely to pass the Congress this year, it is the beginning of a conversation about reforming the tax code.

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 2014. The negative outlook reflects Moody's view that hospitals face a "challenging operating landscape over the next 12-18 months as patient volumes shrink and revenue growth slows." The negative outlook also reflects the struggle for hospitals to reduce costs while "making investment necessary to adjust to changing reimbursement methodologies brought on by the Affordable Care Act (ACA) and the demands of other industry participants such as insurers and employers." 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 has proposed 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. One important benefit of hospital tax exemption 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.

Federal Tax Reform and its Implications for Hospitals. 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 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.

Hospital Tax Exemption. 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 2012 alone, hospitals delivered more than \$45.9 billion (based on 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 wellness programs, community outreach, basic research, medical education and unprofitable services such as burn intensive care, emergency department care, high-level trauma care and neonatal intensive care services. The ability to obtain tax-exempt financing and to accept tax-deductible charitable contributions are two key benefits of hospital tax-exemption that work to make access to hospital services available where needed. The current exemption for hospital services, governed and guided by the community benefit standard, allows the community in which the hospital operates to determine the needs of its residents and the hospital to tailor its activities accordingly. That approach continues to work well for communities across the nation.

America's communities receive a positive return on their investment from the tax-exemption of non-profit hospitals. For two consecutive years, the AHA has collected the community benefit information that tax-exempt hospitals file with the IRS in a form called "Schedule H" and asked Ernst & Young to analyze and report on it. Schedule H forms were obtained directly from hospitals that filed them with the IRS. Data from more than 900 hospitals around the nation show that tax-exempt hospitals consistently provided benefits to the community valued at more than 11 percent of their total expenses, averaging 11.6 percent in 2010 and 11.3 percent in 2009. Direct benefits to patients, which include free care, financial assistance and spending to fill gaps in Medicaid underpayments, averaged 5.7 percent of expenses in both 2010 and 2009. In contrast, federal revenue forgone because of non-profit hospital tax-exemption represents an estimated 2.3 percent of hospital expenses in 2009.

As the IRS plays a more active role in oversight of hospital activities in this area, it has assumed a regulatory role. However, the IRS frequently claims that its guidance is exempt from the notice and hearing requirement of the Administrative Procedures Act (APA), and the agency has failed in the past to comply with the Paperwork Reduction Act. The AHA has drafted a proposal to assure hospitals have the protection of these laws.

Program Integrity

Background

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

No one questions the need for auditors to identify billing mistakes; however, responding to the increasing number of audits and challenging inappropriate denials drains hospitals' time, funding and attention that could more effectively be focused on patient care. For example, according to AHA's *RACTrac* survey of 2,400 participating hospitals, there was a 60 percent increase in the number of records requested for RAC audits during 2013. These Medicare claims now collectively represent almost \$10 billion in Medicare payments, a 56 percent increase from the claims requested for RAC audits through 2012. In addition, through 2013, *RACTrac* data show that hospitals appeal almost half of all Medicare claims denied by a RAC, and in such cases, hospitals are successful at overturning the RAC denial a majority of the time.

AHA View

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.

Hospitals take seriously their obligation to bill properly 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. 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 of these audit contractors is needed by CMS to prevent inaccurate payment denials and to make the auditing effort more transparent, timely, accurate and administratively reasonable.

Audit Relief through Legislation. The Medicare Audit Improvement Act (H.R. 1250/S. 1012) would ensure transparent and fair audit practices and provide assistance to hospitals in mitigating excessive overall audit burden. Introduced by Reps. Sam Graves (R-MO) and Adam Schiff (D-CA) and Sens. Mark Pryor (D-AR) and Roy Blunt (R-MO), this AHA-supported legislation would establish annual limits on documentation requests from RACs and other auditors; 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 without regard for existing filing limitations, among other provisions. Currently, the RAC and MAC programs are allowed to have non-physician auditors review and deny care that a physician determined was necessary for a patient. The Medicare Audit Improvement Act would require a physician to review and approve inpatient medical necessity denials.

Audit Relief through the Courts. Medical necessity represents the top reason RACs deny claims. However, roughly half of the medical necessity denials are not because the RAC believes the care was unnecessary, but rather because the RAC claimed treatment should have been provided on an outpatient basis rather than on an inpatient basis. In these cases, CMS has historically denied the claim in full and only permitted the hospital to only 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, CMS made substantial changes to its rebilling policy. The agency's March 2013 "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. Under the ruling, however, hospitals are not permitted to bill for those services that "require an outpatient status," such as observation services and outpatient visits, including emergency department visits. The ruling applies to new denials made from March 13, 2013 through Sept. 30, 2013, to prior denials that are still eligible for appeal, and appeals currently in process. It allows hospitals to rebill even if the rebilled Part B claim does not meet an existing regulatory requirement that a claim must be filed within one year of the date the services were provided (the one-year timely filing limit).

Also in 2013, CMS separately finalized a rule that specified that hospitals may rebill under Part B only if they meet the one-year timely filing limit, effective for denials of services provided on or after Oct. 1, 2013. While CMS attempted to provide a permanent solution to rebilling problems, the AHA was disappointed that the final rule allows rebilling only for services within the one-year timely filing limit. Since RACs often review claims that are more than a year old, the practical effect is that many denials will be ineligible for rebilling. Therefore, upon analysis of the final rule, the AHA decided to press ahead with litigation in order to ensure that hospitals receive full reimbursement for all reasonable and necessary services, without unreasonable restriction.

An Overburdened Appeals Process. The Department of Health and Human Services (HHS) Office of Medicare Hearings & Appeals (OMHA) in December

2013 announced that it has suspended assignment of appeals to an administrative law judge (ALJ) until it clears a significant backlog in its appeals workload. As a result, hospitals must wait an estimated two years before their appeals are heard by an ALJ, during which time the disputed funds are recouped by CMS. An ALJ is the third level of appeal when a provider appeals a denied claim, and hospitals have experienced a high level of success at the ALJ level. Specifically, the HHS Office of Inspector General has shown that hospitals win an overturn of appealed Part A claim denials 72 percent of the time at this level. According to RACTrac data, hospitals have more than \$1 billion at stake in the appeals process and are now facing several years before they will receive a final determination on appealed claims.

The recent, dramatic increase in the ALJs' workload largely results from inappropriate RAC denials, which motivate hospitals to appeal in order to receive payment for medically necessary services they delivered to Medicare beneficiaries. The AHA urges OMHA and CMS to work together to remedy this situation as soon as possible. In the meantime, CMS should implement policies to mitigate the impact of the ALJ backlog on hospitals, such as not requiring hospitals to repay claims denied by RACs until after an ALJ hearing; enforcing statutory timeframes within which appeals determinations must be made; and addressing systemic issues within the RAC program that lead to avoidable claim denials and appeals.

Preventing Improper Payments. CMS must take 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 exists 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 offers 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

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 Affordable Care Act's (ACA) administrative simplification provisions call for the adoption of operating rules for each HIPAA transaction standard to improve 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 costs 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 creation and advancement of all operating rules. This multi-stakeholder organization has been developing operating rules that support interoperability between payers and providers since 2005. The AHA successfully advocated for revising the CORE's governance model to include a balanced number of provider and health plan representatives, and the first chairman of the new CORE board is a health system chief information officer.

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 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 offer input for existing CAQH initiatives and research, and participate in idea development to increase efficiencies and reduce costs.

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, 2014. Failure to adhere to the operating rules will result in significant penalties for a health plan that is non-compliant. Operating rules already have been adopted for eligibility and claim status, and electronic funds transfer and electronic remittance advice. Additional operating rules are currently under development,

including health plan certification requirements, attachments and enrollment. The attachments rule is expected in 2014 and will enable an electronic response by providers to payer requests for additional information needed to process a claim.

The AHA will continue to participate actively in the development of operating rules and other administrative simplification efforts in collaboration with state and other national hospital associations. We encourage hospitals to join CORE to ensure that the hospital perspective is fully voiced. We also encourage hospitals to engage their clearinghouse vendors and health plans regarding their own ability to take full advantage of the administrative cost savings that will flow from adoption of the operating rules as health plans work to achieve compliance. Hospitals may want to consider ensuring that any clearinghouse or claims processing vendors with whom they contract also are preparing to be certified so that as health plans complete implementation, the benefits of the operating rules will flow from plan to provider.



Regulatory Relief Agenda

Background

Every time a nurse, physician or other caregiver treats a patient, a host of regulations and statutes govern their actions, especially if the patient is a Medicare or Medicaid beneficiary. More than 30 agencies oversee some aspect of the health care delivery process at the federal level alone. No one questions the need for regulations to ensure safe patient care. However, excessive regulations and reporting, outdated laws, a lack of coordination across federal and/or state agencies and a lack of clear federal guidance can combine to inhibit the innovation and cooperation essential to improving and transforming health care delivery. These practices often drain the time and funding that could more effectively be focused on patient care.

In addition, as health care providers respond to the delivery system reforms contained in the Affordable Care Act (ACA), the Department of Health and Human Services (HHS), must update its regulations and regulatory process. Many Medicare regulations were developed for cost-based reimbursement, which depends on discrete silos for each type of provider. However, public policy and market forces are driving providers to break down those silos to provide more coordinated care so patients can transition seamlessly from one type of care or provider to another. To foster that transition, HHS needs to adjust or rewrite regulations to reflect this new way of delivering care. Furthermore, timing and methods used to set regulatory policies are making it difficult for health care providers to stay abreast of the growing volume and complexity of regulatory requirements.

AHA View

The AHA is concerned about the mounting regulatory burden faced by America's hospitals and its impact on patients and communities. We have identified several areas and/or regulations that impede hospitals' ability to provide care to their communities and to improve care delivery. Below are some of the key policies needing reform:

- Remove barriers to clinical integration;
- Update Medicare Conditions of Participation;
- Rein in Recovery Audit Contractors;
- Amend the False Claims Act;
- Extend federal requirements for adoption of electronic health records (EHRs);
- Streamline and coordinate quality measures reported to payers;
- Simplify administrative requirements of payers, and
- Reform the medical liability system.

The AHA also is concerned about the increasing use of sub-regulatory guidance, such as agency-issued Frequently Asked Questions (FAQs), to articulate new or revised policy in ways that do not provide for constructive public input and are often difficult to identify or track.

Clinical Integration. Clinical integration is needed to facilitate the coordination of patient care across conditions, providers, settings and time to achieve better health and health care at lower costs. At its heart, clinical integration is team-work: hospitals, doctors, nurses and other caregivers working together to make sure patients get the right care, at the right time, in the right place. Over the years, many hospitals have made tremendous strides in improving coordination across the care continuum, but they first had to overcome the legal barriers that stand in the way. Barriers to clinical integration range from confusing antitrust policies to outdated rules governing relationships between hospitals, doctors and other caregivers. Even Internal Revenue Service (IRS) rules can be a barrier.

There are solutions. They range from creating user-friendly antitrust guidelines and safe harbors, to providing clear congressional direction on existing rules that promote, instead of hinder, clinical integration efforts. The AHA has identified eight specific barriers and provided solutions to the administration. While there has been some limited progress in the context of implementing the Accountable Care Organization (ACO) provisions of the ACA, more needs to be done. For an in-depth analysis, see the AHA March *TrendWatch*, “The Value of Provider Integration.”

Updating the Medicare Conditions of Participation (CoPs). The CoPs are the comprehensive set of standards that are used to determine whether a health care provider should be certified to participate in the Medicare program. As such, it is important that the CoPs stay abreast of evolving standards of care and approaches to health care delivery that are capable of meeting changing public and payer expectations. In 2012, the Centers for Medicare and Medicaid Services (CMS) proposed the first comprehensive update of the CoPs since the 1980s. We expect the agency to release three additional regulations related to the CoPs in the first half of 2014.

Governance. CMS is expected to release a final rule that could affect the governance structures of some hospitals. The AHA was supportive of many of the proposed changes in the governance rule, such as CMS’s intention to rescind a requirement that hospitals must have a member of the medical staff on the governing board and replace it with periodic consultation between the board and a medical staff member. We are very concerned, however, about CMS’s proposal to prohibit 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. This proposal runs counter to efforts to encourage greater integration of health care providers to promote improvements in care, greater efficiency, and more standardization of practice in accordance with current science.

Life Safety Code (LSC). On April 14, CMS released a proposed rule related to the LSC requirements embedded in the CoPs. Currently, the CoPs reference the 2000 version of the LSC, even though it was updated in 2012. The AHA believes that CMS should defer to the requirements of the most up-to-date version of the LSC.

Influenza Vaccinations. CMS could release a final rule that may require hospitals, critical access hospitals (CAHs) and other providers to offer flu shots to all inpatients and outpatients during flu season. The AHA urged CMS not to finalize this requirement. First, it is more difficult for hospitals to verify a patient's contraindications than a primary care provider. Second, such a requirement would be costly for hospitals to operationalize because they would need to add nursing and pharmacy staff.

Recovery Audit Contractors (RACs). Hospitals strive for payment accuracy and are committed to working with CMS to ensure the accuracy of Medicare and Medicaid payments. However, the existence of multiple and overlapping auditing programs, including RACs, has subjected hospitals to duplicative audits, unmanageable medical record requests and inappropriate payment denials. According to AHA's RACTrac survey of 2,400 participating hospitals, there was a 60 percent increase in the number of records requested for RAC audits during 2013. These Medicare claims now collectively represent almost \$10 billion in Medicare payments, a 56 percent increase from the claims requested for RAC audits through 2012.

Hospitals are drowning in the deluge of unmanageable medical record requests and inappropriate payment denials. CMS and Congress need to make the audit processes fairer and more transparent. The Medicare Audit Improvement Act (H.R. 1250/S. 1012) would implement transparent and fair audit practices and assist hospitals in mitigating excessive overall audit burden. Introduced by Reps. Sam Graves (R-MO) and Adam Schiff (D-CA) and Sens. Mark Pryor (D-AR) and Roy Blunt (R-MO), this AHA-supported legislation would establish annual limits on documentation requests from RACs and other auditors; 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 without regard for existing timely filing limitations, among other provisions. Refer to the AHA issue paper, "Program Integrity," for more information.

Abuse of the False Claims Act (FCA). The Department of Justice and certain Assistant United States Attorneys have abused their authority by initiating FCA investigations of hospitals upon the discovery of evidence of a mistake or overutilization. They have seized upon data analysis that flags billing errors and converted them into a presumption of FCA liability. FCA cases pose great risk to hospitals in terms of monetary and administrative sanctions. The threat of FCA liability leads hospitals to incur massive expenses related to retaining specialized counsel and outside forensic accountants and, in the event an overpayment is discovered, to negotiate a formal FCA settlement where a simple cost report adjustment is all that is necessary. The Fairness in Health Care Claims, Guidance and Investigations Act, H.R. 2931, would ensure that unintentional billing disputes are not pursued and penalized as fraud. Introduced by Reps. Howard Coble

(R-NC) and David Scott (D-GA), this AHA-supported bill would amend the FCA by requiring that federal agencies review their own rules and regulations to determine whether a billing dispute should be pursued as fraud before launching an investigation, and assuring that unintentional billing disputes are not penalized as harshly as fraud.

Medicare and Medicaid EHR Incentives and Certification. In fiscal year (FY) 2014, all hospitals and physicians must upgrade to the 2014 Edition Certified EHR and meet higher performance requirements for meaningful use under Medicare and Medicaid. Hospitals paid under the inpatient prospective payment system will not only miss out on incentives if they cannot meet these requirements, but also will be subject to significant subsequent payment penalties under Medicare. The new requirements are highly proscriptive, and do not always match sensible workflows. They also make the performance of the provider dependent on the actions of others, including other providers and patients, and assume a level of health information exchange infrastructure that does not yet exist. Given the complexities of the program, and the delays in delivery of certified EHRs from vendors, the AHA has advocated extending the 2014 timelines and providing greater flexibility in the meaningful use criteria. Refer to the AHA issue paper, “Health Information Technology,” for an in-depth analysis.

Quality Measures. Both public quality reporting and value-based purchasing programs improve hospital quality and patient safety. To date, however, federal quality reporting and payment programs have proliferated without strong alignment to specific, measurable national improvement objectives and goals for quality improvement. As a result, the sheer volume of measures and disparate ranking and rating efforts has become overwhelming and distracting to providers and the public. Quality improvement efforts with different priorities, goals and incentives impede efforts to enhance coordination across the care continuum. The challenge of meeting multiple, and often non-aligned, quality measurement and reporting requirements poses a significant burden to hospitals and other providers in collecting data. Unaligned, disparate requirements confuse the public and other users of the data as they attempt to assess how well the health care system as a whole, or their community providers, are doing. And, most importantly, non-alignment becomes an impediment for improvement efforts in trying to determine which practices and processes are most likely to lead to the best outcomes for patients.

To improve the alignment of federal quality reporting and value-based purchasing programs, the AHA urges CMS to establish a limited number (e.g., three to five) of clear, meaningful national goals for quality improvement with specific and measurable objectives that could be used for all of the agency’s programs. These goals would be the same across payment programs; the decision to use particular measures in a particular program would be driven by a consistent set of principles. The national goals for quality improvement also should be applied to CMS’s

related regulatory activities around quality, such as CoPs and conditions of coverage. To learn more, refer the AHA's "Quality Reporting and Pay-for-Performance Programs" issue paper.

Administrative Simplification. Simplifying and standardizing administrative requirements across all payers is a critical component of AHA's regulatory agenda because it can reduce administrative costs for all stakeholders – providers and health plans alike. 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 AHA-supported administrative simplification provisions of the ACA call for the adoption of operating rules for each HIPAA transaction standard to improve its 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. Refer to the AHA issue paper, "Administrative Simplification," for more details.

Medical Liability Reform. The increased costs that result from our flawed medical liability system not only hinder access to affordable health care, but also raise health care premiums and costs for everyone. The AHA supports a more sensible liability system that promotes use of 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;
- Enact a reasonable statute of limitations after the date of the manifestation or discovery of an injury; and
- Establish "safe harbor" protections for providers who follow evidence-based clinical practice guidelines.

To learn more, refer to the AHA's "Medical Liability Reform" issue paper.

Use of Sub-regulatory Issuances for Policy Matters. Increasingly, federal agencies are developing policy through the issuance of sub-regulatory guidance. The Medicare and Medicaid EHR Incentive Programs include a large number of

specific requirements promulgated through regulation and sub-regulatory guidance. Health care providers and the vendors that serve them are often challenged to fully understand and stay abreast of regulatory requirements for certification and meaningful use requirements. For example, CMS has published more than 150 FAQs, while the Office of the National Coordinator for Health IT has issued more than 20. The use of sub-regulatory issuances has been substantially magnified during the implementation of the new health insurance marketplaces. Although sub-regulatory guidance may be available through town hall meetings, webinars and in various locations on the HHS, CMS and departments of Labor and Treasury websites, the information sometimes conflicts within and between sites, can be hard to find and may be difficult to understand. In addition, though FAQs can be helpful in providing clarification on issues not addressed in sufficient detail in regulation, in practice some FAQs have resulted in uncertainty. The FAQs also are established on an ad hoc basis, and are not tied to any routine schedule or process of updates, which makes it challenging for providers to stay abreast of changes. Hospitals need predictability and certainty in order to navigate the transforming health care delivery landscape. The AHA urges government agencies to refrain from the use of FAQs and instead allow for appropriate public notice and comment.



American Hospital
Association®

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 hinder access to affordable health care and raise health care premiums and costs. The Congressional Budget Office and other deficit reduction committees have found that medical liability reform could save \$17–\$62 billion over 10 years, depending on the policies implemented.

AHA View

The AHA supports a more sensible liability system that relies upon 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;**
- **Enact a reasonable statute of limitations after the date of the manifestation or discovery of an injury; and**
- **Establish “safe harbor” protections for providers who follow evidence-based clinical practice guidelines.**

In recent years, several bills were introduced that would have helped curb escalating medical liability costs, including comprehensive legislation based on California's Medical Injury Compensation Reform Act (MICRA), which capped non-economic damages and attorneys' fees, among other reforms. These federal bills have repeatedly failed to pass both houses of Congress. While the AHA continues to press for comprehensive reform, we anticipate that during 2014, legislators will focus on more limited but targeted solutions to reform the medical liability system.

Legislation introduced in the 113th Congress includes:

- **Health Care Safety Net Enhancement Act of 2013 (H.R. 36/S. 961) –** This AHA-backed legislation provides medical liability protections under the Federal Tort Claims Act to hospitals and physicians providing emergency care during a federally declared national disaster. Specifically, the bill extends to hospitals, emergency departments and physicians who provide services pursuant to the Emergency Medical Treatment and Labor Act, the same medical liability protections given to employees of Community Health Centers. The bill's sponsors are Sen. Roy Blunt (R-MO) and Rep. Charlie Dent (R-PA).

- Medical Care Access Protection (MCAP) Act of 2013 (S. 44) – Introduced by Sen. Rob Portman (R-OH), this AHA – supported legislation establishes a statute of limitations for lawsuits for medical liability claims of three years after the date of manifestation of an injury or one year after discovery. Additionally, this bill makes each party liable only for the amount of damages directly proportional to liability, limiting non-economic damages to \$250,000 from the health care provider, and a total of \$500,000 from multiple health care institutions. Under this legislation courts would be required to limit contingency fees paid to attorneys.
- Steps Toward Access and Reform Act of 2013 (S. 1860) – Introduced by Sen. Dean Heller (R-NV), this legislation includes several MICRA-based provisions, such as capping noneconomic damages and limiting the time a claimant may file a lawsuit. It also seeks to improve access to rural health care by directing the secretary of Health and Human Services (HHS) to provide loan repayment up to \$100,000 for primary care providers who agree to serve in a medically underserved community for a period of at least four years.
- Standard of Care Protection Act of 2013 (H.R. 1473/S. 1769) – This legislation would limit the establishment of certain standards of care or duties of care owed by health care providers to patients in any medical malpractice or medical product liability action or claim. The bill was introduced by Reps. Phil Gingrey (R-GA) and Henry Cueller (D-TX) and Sens. Thomas Carper (D-DE) and Pat Toomey (R-PA).
- Saving Lives, Saving Costs Act of 2014 (H.R. 4106) – Introduced by Reps. Andy Barr (R-KY) and Ami Bera (D-CA), this bill seeks to establish “safe harbors” from medical liability lawsuits for those health care professionals following certain clinical guidelines. H.R. 4106 would apply to care involving a federal payer and would instruct HHS to work with professional organizations to determine which clinical guidelines would create “safe harbors.”

Administrative Compensation System. The AHA 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.