The Return on Your Dues Investment

Below you'll find just a few highlights of the ways the American Hospital Association (AHA) has been working for you. You can find even more at www.aha.org under "Value of Membership."

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

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

Ensuring Needed Resources

- **Medicaid Disproportionate Share Hospital (DSH) payments.** Worked with Congress to delay scheduled cuts to Medicaid DSH payments for the next three years.
- **'Two-midnight policy.'** Secured several partial legislative and regulatory enforcement delays of the Centers for Medicare & Medicaid Services' (CMS) two-midnight policy for inpatient admission and medical review criteria. Under the enforcement delay, recovery auditors and other Medicare review contractors will not conduct post-payment patient status reviews of inpatient hospital claims with dates of admission on or after Oct. 1, 2013 through March 31, 2015. AHA continues to urge CMS to fix the critical flaws of the underlying policy by immediately engaging stakeholders to find a workable solution that addresses the reasonable and necessary inpatient-level services currently provided by hospitals to Medicare beneficiaries that are not expected to span two midnights.
- **Medicare physician payment.** Worked with Congress to prevent a 24% cut to Medicare physician payments that was scheduled to take place Jan. 1. The cut has been delayed through March 31, 2015.
- **Extension of Medicare provisions.** As part of the most recent Medicare physician payment fix, AHA worked with Congress to extend several provisions of importance to hospitals through March 31, 2015, including: ambulance add-on payments, the enhanced low-volume adjustment, the Medicare-dependent hospital program, and the outpatient therapy cap exceptions process.
- **Medicare Advantage (MA) and sequestration.** Successfully urged CMS to confirm in writing that the 2 percent Medicare payment reduction under federal sequestration does not change Medicare fee-for-service rates or fee schedules, but applies only to the final payment amount. AHA sought the clarification last summer after hospitals reported that some Medicare Advantage Organizations were inappropriately passing their sequestration cut on to providers, apparently due to confusion over how the policy could affect certain payment terms used in MA contracts with providers.

Reducing Red Tape

- **Recovery Audit Contractors (RAC).** Along with limitations on RACs related to the two-midnight policy, in response to concerns voiced by AHA, CMS is making a number of changes to the RAC program, effective with the next round of contracts. CMS will encourage use of the pre-appeal discussion period to resolve disputes over RAC audits by requiring RACs to promptly acknowledge hospitals' requests for a discussion. Further, CMS will prohibit RACs from referring denied claims for recoupment until at least 30 days has passed, so that hospitals are not forced to choose between using the discussion period and appealing the claim. CMS also will establish limits on the number of medical records RACs can review based on claim type, and will adjust hospitals' medical records limit based on error rate. Also, in January, AHA launched a new online tool that allows hospitals to compare the impact of Medicare's RAC program based on RAC region, bed size, ownership status and other variables. Hospitals can use the RACTrac Analyzer with AHA's existing RACTrac survey to create reports that compare their hospital's RAC activity with those of similar hospitals.
- **Medicaid presumptive eligibility.** Convinced CMS to clarify that hospitals can continue to use service vendors to assist them in making Medicaid presumptive eligibility determinations under the Affordable Care Act (ACA).
- **Outpatient supervision.** Worked with CMS's Advisory Panel on Hospital Outpatient Payment (HOP Panel) to secure its recommendation to reduce the supervision level for a number of outpatient therapeutic services from direct to general supervision, meaning the service could be performed under the overall direction of a physician or an appropriate non-physician practitioner without requiring their presence. Among the seven services that CMS has now approved for general supervision are: blood transfusions; declot vascular devices; withdrawal of

arterial blood; chest wall manipulation; subcutaneous infusion (each additional hour) and activity. CMS is soliciting further input on reducing the level of supervision for eight chemotherapy administration services.

- **Clinical Laboratory Improvement Amendments (CLIA).** Successfully urged CMS to provide the Health and Human Services (HHS) Secretary with discretion as to which sanctions may be applied to cases of intentional referral of proficiency testing (PT) samples to another laboratory, consistent with the requirements of the Taking Essential Steps for Testing Act of 2012 to allow for a better fit between the nature and extent of the intentional PT referral incident(s) and the type and extent of corrective actions that are imposed. We are pleased that CMS has incorporated several of the AHA's recommendations into the final rule, particularly the provision that allows CMS to limit the reach of a ban on laboratory ownership in instances in which a PT referral occurred in only one laboratory that is part of a health system that includes laboratories in many locations.
- **Rural Health Clinic (RHC) staffing.** Worked with CMS to finalize provisions that permit additional flexibility in staffing of RHCs by allowing them to contract with non-physician practitioners, such as physician assistants and nurse practitioners. This should provide RHCs with regulatory relief and allow them to utilize individualized approaches to appropriately staff their facilities with non-physician practitioners.
- **Stage 3 meaningful use.** Secured a delay until fiscal year (FY) 2017 for the start of Stage 3 requirements for meaningful use of electronic health records (EHR) under the Medicare and Medicaid EHR Incentive Programs. AHA welcomed the one-year delay in the Stage 3 start date, but we remain concerned the timeline is too agressive. AHA also helped secure an expanded hardship exception for penalties for failure to meet meaningful use that begin in FY 2015.
- **Meaningful use flexibility.** Successfully urged CMS to provide hospitals and eligible professionals (EPs) with flexibility in meeting meaningful use in 2014 so that they can earn promised incentives and avoid future payment penalties. In May, CMS proposed allowing hospitals and EPs multiple pathways to meet meaningful use in 2014, including using the 2011 Edition Certified Electronic Health Record Technology to meet the meaningful use requirements in place for 2013.
- **EHRs and 'upcoding.'** Continued to provide data and research to counter administration claims that hospitals are using EHRs to inappropriately increase reimbursements from Medicare through upcoding. AHA sent a letter to HHS Secretary Burwell and Attorney General Eric Holder highlighting a study that found "no empirical evidence to suggest that hospitals are systematically using [EHRs] to increase reimbursement" from Medicare. The authors concluded that their findings "should offer considerable reassurance" to policymakers, and suggest that policymakers "do not need to devote substantial effort to combat such behavior." They added that a "largescale policy effort targeting EHR-driven fraudulent coding … is not likely to be useful." The study is available at: *http://tinyurl.com/pkqokp6*.
- **Protections for health infomation technology (IT) donations.** Consistent with AHA input, CMS and the HHS Office of Inspector General extended through 2021 the regulatory protections under the Stark and antikickback laws for health IT donations from hospitals to physicians. The protections were set to expire in 2013. AHA continues to urge the agencies to make the protections permanent.
- **Medicare Conditions of Participation (CoPs).** Successfully advocated for CMS to revise the CoPs to allow greater flexibility for hospital medical staff structures and to remove an overly prescriptive regulation relating to the governing board composition.
- **Hospital Mortgage Insurance Program.** Worked with Congress to extend until July 31, 2016, the exemption from the so-called "patient day test" for CAHs under the Federal Housing Administration's Hospital Mortgage Insurance Program (Section 242). Congress recognized the limitations of the "patient day test" as it applied to CAHs, and exempted them from its requirements in 2006. That exemption had expired on July 31, 2011.
- **Long-term care hospital (LTCH) reform.** CMS will begin to roll out in October 2015 patient admissions criteria for LTCHs that were enacted by Congress. While stringent, the new criteria will provide regulatory stability that serves as a bridge to future delivery system reforms. In addition, the criteria were accompanied by four years of much needed "25% Rule" relief.

Improving Health Care Quality

- **HRET Hospital Engagement Network.** More than 1,500 hospitals participating in the AHA's Health Research & Educational Trust (HRET) Hospital Engagement Network prevented more than 143,000 harms with associated cost savings of $1.3 billion. Among other improvements, participating hospitals prevented 19,000 early elective deliveries (which can increase complications); more than 110,000 readmissions; and more than 8,500 infections. The program is part of CMS's Partnership for Patients initiative.
- **Good stewardship of health care resources.** An AHA white paper on appropriate use of medical resources includes a "top five" list of hospital-based procedures or interventions that should be reviewed and discussed by a patient and physician before proceeding. AHA has released toolkits on blood managment and antimicrobial stewardship. In coming months, AHA will release additional resources and best practices to support appropriate use of these procedures and interventions.

Preparing the Delivery System of the Future, Today

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