American Hospital Association®

The Value of Membership in the American Hospital Association

Community Hospitals

Community hospitals are the cornerstone of health and healing in America's communities – large and small, urban and rural. Hospitals are working not just to deliver quality care, but to improve the patient experience and population health, while reducing the per capita cost of care. This work includes inpatient acute care and also extends far beyond the hospital building to include access to primary care, post-acute care, public health and wellness, housing, job training, back-to-school immunizations, literacy programs and many other resources. A community hospital's efforts are often greeted with little fanfare, as it seamlessly coordinates the community's health delivery system. However, its role is essential to the health and economic well-being of the people it serves.

Below are just some of the ways AHA works for America's community hospitals.

Related Resources

AHA Advocacy Alliances

Community Connections

AHA Section for Metropolitan Hospitals

Working for Community Hospitals | Engaging Community Hospital Leaders | Providing Key Resources

Working for Community Hospitals

Outdated regulations, duplicative or conflicting rules, and unworkable timelines – all of these increase the burden on community hospitals and draw much-needed resources away from patient care. AHA consistently works for you demonstrating the need for streamlined regulations, common sense rules and manageable timelines, as outlined below.

- **Ensured Passage of Medicare SGR Legislation.** AHA worked with Congress to pass bipartisan legislation to replace the flawed Medicare physician sustainable growth rate (SGR) formula. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) contained extensions of several programs critical to small and rural hospitals, a two-year extension to the Children's Health Insurance Program, and modifications to the Civil Penalties law to enable hospitals and physicians to better work together to improve care for patients. Included among these changes are extensions of the:

- Medicare-Dependent Hospital program until Oct. 1, 2017
- Therapy cap exceptions process until Jan. 1, 2018
- Medicare home health rural add-on until Jan. 1, 2018
- Partial enforcement delay of "two-midnight" policy until Oct. 1, 2015
- Work Geographic Practice Cost Index for physicians until Jan. 1, 2018
- Increased hospital payment adjustment for certain low-volume hospitals until Oct. 1, 2017
- Ambulance add-ons for ground ambulance services and super rural areas until Jan. 1, 2018

While AHA is disappointed that hospital cuts were used as a partial offset to MACRA, the legislation rejected a number of flawed policy options that would be harmful to hospitals, such as reduction to outpatient hospital services (so-called "site-neutral" cuts); reductions to Medicare bad debt payments; and further delays to the ICD-10 program.

- **Advocated for Significant Changes to the Recovery Audit Contractor Program.** H.R. 2156, the Medicare Audit Improvement Act of 2015 would make significant, fundamental changes to the Recovery Audit Contractor (RAC) program. The legislation would:
  - Eliminate the contingency fee structure
  - Reduce payments to RACs that are inaccurate in their audit determinations and have high appeals overturn rates
  - Fix the CMS' unfair rebilling rules
  - Require RACs to make their inpatient claims decisions using the same information the physician had when treating the patient

  RAC-related news, resources and educational materials can be found at *www.aha.org/RAC*.
- **Proposed Recommendations for CMS Comprehensive Care for Joint Replacement (CCJR) Bundled Payment Program.** AHA was pleased that CMS's final rule on the Comprehensive Care for Joint Replacement Payment Model made several critical improvements at AHA's urging which will help provide the support hospitals need to be successful under the program and better serve patients. Under this model, that will be implemented in 67 geographic areas, the hospital in which the joint replacement takes place will be held financially accountable for quality and costs for the entire episode of care, from the date of admission through 90 days post-discharge. In response to AHA's request, CMS delayed the start date to April 1, 2016 instead of Jan. 1, 2016 and reduced the limits it sets on hospitals' repayment responsibility to Medicare. In addition, CMS chose not to finalize its proposal to require hospitals to achieve 30th to 40th percentile of performance on specific quality measures to be eligible for reconciliation payments favoring a composite quality score instead. Participating hospitals may share hospital internal cost savings and payment received from Medicare as a result of reduced episode spending with collaborating providers and suppliers. And, although the final rule does not include any waivers to the fraud and abuse laws, CMS and the Department of Health and Human Services Office of Inspector General issued a joint statement that waives the federal Anti-kickback statute and the physician self-referral law with respect to certain financial arrangements.
- **Promoted Equity in Hospital Readmissions.** The Hospital Readmission Reduction Program (HRRP) requires CMS to penalize hospitals for "excess" readmissions when compared to "expected" levels of readmissions. America's hospitals are strongly committed to reducing unnecessary readmissions. However, three years of experience with the HRRP shows that hospitals caring for the poorest patients are disproportionately more likely to incur a penalty. AHA supports the *Establishing Beneficiary Equity in the Hospital Readmission Program Act of*

2015 (S. 688/H.R. 1343) to ensure that hospitals caring for our nation's most vulnerable patients are not unfairly penalized under the HRRP.

- **Promoted Flexibility in Health IT Reporting.** AHA worked with CMS to propose a shortened meaningful use reporting period for 2015 to a 90-day period aligned with the calendar year and to provide additional flexibilities, including reducing the share of patients that must use the patient portal from five percent to at least one percent.


Setting the Record Straight on 340B:
Fact vs. Fiction

- **Encouraged Support for the 340B Drug Pricing Program.** AHA urged the House Energy and Commerce Health Subcommittee to preserve the 340B Drug Pricing Program. AHA continues to support the Health Resources and Services Administration's (HRSA) efforts to improve the 340B program for eligible hospitals and clinics, including discounts for orphan drugs. In response to its detractors, AHA's "Setting the Record Straight on 340B" fact sheet(http://www.aha.org/content/14/340BFactvsFiction.pdf) separates fact from fiction on the 340B program. AHA is preparing its rebuttal on the recent HRSA omnibus guidance on the 340B program that proposed revising the definition of patient eligibility and eliminating infusion services among other issues.
- **Facilitated Improved Health Care Access for Veterans.** The Veterans Choice Program (VCP) allows qualifying veterans to elect to receive hospital care and medical services from non-Veterans Affairs (VA) entities and providers when a veteran lives more than 40 miles away from or cannot be seen within 30 days at a VA facility. In written comments to the U.S. Department of Veterans Affairs, AHA expressed concern that the VA's interpretation of the 40-mile criterion unreasonably restricts many veterans' ability to access health care and offered suggestions for improving the program with respect to the mileage requirement, timely payment of claims and contracting to provide care. The VCP will now use driving distance to determine the distance between a veteran's residence and the nearest VA medical facility. Non-VA medical care providers may participate in the VCP by joining the Patient-Centered Community Care Network or by signing a provider agreement with Health Net Federal Services or TriWest Healthcare Alliance. For more information, the Veterans Choice website is: www.va.gov/opa/choiceact.
- **Urged the Internal Revenue Service (IRS) to Support Community Benefits.** AHA and the Catholic Health Association of the United States (CHA) urged the IRS to formally acknowledge that hospitals' support for improved housing to enhance community health is a community benefit and should be recognized on page one of Form 990 Schedule H.
- **Collaborated with National Organizations.** AHA works closely with many other national organizations to drive positive change in federal policies and improve care across the continuum. Liaison relationships are maintained with organizations including state and local hospital associations, CHA and America's Essential Hospitals, to name a few.
- **Guided the Work of The Coalition to Protect America's Health Care.** The Coalition is a recognized leader in digital advocacy, forming through social media and online ads a grassroots army of more than one million individuals who communicate directly to Congress about the harm cuts in hospital payments could have on patient care.

- **Provided Resources Via the Advocacy Action Center.** This web-based kit provides a set of resources and materials tailored to help hospital executives effectively communicate key messages and explain concerns to legislators, the hospital family and the community at large.

A comprehensive list of AHA's work can be found at www.aha.org/value.

Engaging Community Hospital Leaders

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

- **Task Force and Meetings on Ensuring Access to Care in Vulnerable Communities.** The AHA Board has created a 30-member task force to focus on ensuring access to care in at-risk communities. The Task Force on Ensuring Access in Vulnerable Communities consists of two subcommittees that will examine the issue from the rural and urban perspectives. The task force convened members in September 2015 to begin the work and plans to send a report to the AHA Board of Trustees in mid-2016. During that time frame field hearings will be held for broader member input.
- **Governance and Policy-making Roles.** AHA offers community hospital leaders many opportunities to take an active role in shaping AHA policies and setting direction for the association. These opportunities include serving on AHA's Board of Trustees, Regional Policy Boards, Governing Councils and Committees. In addition, the association creates short-term advisory and work groups where members weigh in on more focused, time-sensitive policy issues.
- **Advocacy Alliances.** AHA's Advocacy Alliances provide members with another way to engage legislators on the specific issue or issues that have a direct impact on their ability to continue providing quality health care services in their communities. TheAdvocacy Alliance for the 340B Drug Pricing Program focuses primarily on preventing attempts to scale back this vital program and supports expansion of 340B discounts. The Advocacy Alliance for Graduate Medical Education focuses on advocacy related to funding and ensuring an adequate supply of physicians. The Advocacy Alliance for Coordinated Care focuses on ensuring payment rates remain fair and equitable in the hospital outpatient setting for evaluation, management and other services, and for post-acute care providers. The Advocacy Alliance for Rural Hospitals focuses on advocating for appropriate Medicare payments, working to extend expiring Medicare provisions that help rural hospitals maintain financial viability and improving federal programs to account for specialized funding for special circumstances in rural communities.
- **Member Outreach.** Several times throughout the year, AHA's hospital member CEOs are individually contacted by AHA staff and/or are invited to participate in small group CEO conference calls to discuss key AHA initiatives. During the calls, members contribute their perspectives and often receive additional tools and resources to address key challenges shared during the discussions.

Providing Key Resources for Community Hospitals

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

- **AHA's Enrollment Toolkit.** AHA's enrollment toolkit supports hospitals' efforts to help consumers enroll in the Health Insurance Marketplace. The toolkit contains links to key resources from AHA and other national and local organizations, as well as case examples from hospitals on their enrollment efforts. AHA "Get Enrolled!" webpage (www.aha.org/GetEnrolled) is continually updated with resources to help hospitals connect their community to coverage.
- **Equity of Care.** Addressing disparities is essential for performance excellence and improved community health. AHA issuedgoals and milestones from the National Call to Action, launched in 2011 to end health care disparities and promote diversity, and encourages hospitals to take the #123forEquity Pledge to eliminate health care disparities.
- **Veterans Hiring Resource.** Hospital Careers: An Opportunity to Hire Veterans is a toolkit for hospitals with guidance on recruiting veterans into hospital careers. The resource aims to assist hospitals in hiring veterans with clinical experience, as well as talent and leadership skills beyond their medical credentials.
- **Cybersecurity Resource.** AHA invites members to listen to a new cybersecurity audio-cast series, *Cyber 911: Responding to a Cybersecurity Breach*. By listening to four short dialogues, health care leaders can gain a better understanding of what preparations their organizations need to take to respond effectively when a cybersecurity breach occurs. Each part can be downloaded at www.aha.org/advocacy-issues/cyber911.shtml.
- **Policy Reports and Research.** The AHA's Committee on Research (COR) develops the AHA research agenda, studies topics in depth, and reports findings to the AHA Board and the field. Together with the Committee on Performance Improvement, COR released a report examining the changing health care landscape and the role trustees and community leaders can play to help guide hospitals during this time of change. The report includes a toolkit for initiating community conversations and engaging trustees in the redefinition of the "H". Other AHA research reports have focused on patient engagement and advanced illness management.
- **Media Communications.** In national news and traditional and social media, in print and on television and radio, the AHA advocates for hospitals and health care systems. The AHA also equips health care system executives with tools and strategies to help respond to media inquiries on difficult and challenging issues. Sign up to follow the AHA on Twitter, YouTube and Facebook. AHA launched a digital campaign to help patients and consumers better understand the evolving role of the nation's hospitals. The website, www.AdvancingHealthinAmerica.org, features a video and other resources showing how hospitals are creating partnerships and programs that reach beyond their walls to improve community health and access to care.

- **HPOE Guides and Reports.** The AHA's Hospitals in Pursuit of Excellence (HPOE) shares action guides and reports to help accelerate performance improvement. For example, *The Second*

Curve of Population Health builds upon prior AHA reports that outline a road map for hospitals to use as they transition to the second curve of population health.

- **Physician Leadership Forum (PLF).** AHA's PLF seeks to foster strong collaborative relationships between hospitals and physicians through education, quality and patient safety, leadership development, and advocacy and public policy. Through webinars, seminars and reports, PLF has focused on team-based care, physician competency development and physician practice management.
- **RAC*Trac*.** The AHA RAC*Trac* website provides information on the RAC survey that collects data from hospitals on a quarterly basis to assess the impact of the Medicare RAC program on hospitals. The site also offers webinars and reports that highlight the survey findings and provides access to the RAC*Trac* analyzer tool that compares similar hospitals' RAC activity.
- **ICD-10 Executive Action Guide.** AHA's *ICD-10 Executive Action Guide* helps hospital and health system leaders with their transition to the new ICD-10 coding system. The guide highlights four areas that are critical to implementation and provides a roadmap to benchmark progress.
- **Price Transparency Toolkit.** AHA developed *Achieving Price Transparency for Consumers: A Toolkit for Hospitals* to provide resources for hospitals to assess their current price transparency efforts. It can be found at *www.ahacommunityconnections.org*. AHA also contributed to the Healthcare Financial Management Association's Understanding Health Care Prices: A Consumer Guide to help consumers compare prices among providers and manage their out-of-pocket costs. A copy of the report can be found at *www.hfma.org*.
- **AHA Resource Center.** Highly trained information specialists assist members in accessing timely and relevant health services articles and data.