

This has been a landmark year for health care: Among other achievements, we saw passage of bipartisan legislation to fix the flawed Medicare physician payment formula, and the validity of the insurance subsidies provided by the Affordable Care Act were upheld by the Supreme Court. Below are just some of the advances we have made this year by working together and speaking with one voice to advocate for hospitals and the patients and communities they serve. For more, visit www.aha.org/value.

Preserving and Expanding Patients' Access to Care

Access to affordable health insurance is critical for maintaining health. Over the past year, the AHA focused on:

- **Preserving Subsidies for Health Coverage** – AHA helped protect subsidy payments for health insurance for more than 14 million Americans by aggressively advocating on behalf of patients during the landmark *King v. Burwell* case.
- **Protecting Patients from Insurer Consolidation** – AHA is working to ensure that the recently proposed acquisitions involving four of the five major national insurers receive the highest level of scrutiny. AHA has provided analysis to the Department of Justice and testified before Congress numerous times, introducing into the record concrete reasoning why the acquisitions would decrease competition and hurt the marketplace, in addition to working to educate the media and the public on the potential consequences for patients and providers.
- **Expanding Access to Medicaid** – AHA continues to support state hospital associations in non-expansion states to make the case for Medicaid expansion.
- **Ensuring Hospital Coverage in Health Plans** – AHA worked successfully with the Department of Health and Human Services to ensure that health plans in 2016 and beyond do not exclude inpatient hospital coverage. Large employers are required to offer employees an affordable health plan that meets or exceeds the “minimum value threshold” of covering at least 60 percent of expected costs. Reports had indicated that some health plans meeting the threshold excluded or had minimal inpatient hospital coverage. The Centers for Medicare & Medicaid Services responded and stopped the proliferation of these types of plans. AHA will continue to engage on this issue as CMS and the Internal Revenue Service look to develop further guidance.
- **Fighting Escalating Drug Prices** – As a member of the steering committee of the Campaign for Sustainable Rx Pricing, along with AHIP and AARP, AHA has raised awareness with legislators, policymakers and the media of how rising prescription drug prices are putting a strain on the entire health care system.

AHA also helped persuade Congress to increase veterans' access to timely care in the private sector. In addition, we continue to promote the integration of behavioral and physical health by advocating for federal mental health legislation, as well as providing education and innovative case models to members.

Fighting for Commonsense Regulation

Overly burdensome regulations divert time and resources away from patient care. In 2015, AHA worked to revise several notable policies, including:

- **Two-midnight Refinements** – AHA helped persuade CMS to finalize several positive changes to its two-midnight policy, including allowing for case-by-case exceptions based on the physician’s judgement. AHA also was successful at obtaining delayed enforcement of the two-midnight policy through Dec. 31. In addition, AHA influenced positive changes to the agency’s medical review strategy, and CMS will now use Quality Improvement Organizations to conduct first-line medical reviews of the majority of patient status claims rather than Medicare Administrative Contractors or Recovery Audit Contractors. A federal court also recently ordered CMS to go back and re-justify its associated 0.2% payment cut in response to lawsuits brought by AHA and others.
- **Electronic Health Record Incentive Program Enhancements** – AHA helped persuade CMS to shorten the reporting period for 2015 to 90 days instead of a full calendar year. AHA also convened an advisory group on interoperability and worked with regulators to improve standards for information sharing and vendor accountability.
- **RAC Program Improvements** – AHA worked with CMS to make changes to the RAC program, including limiting the look-back period for patient status reviews to six months after the date of service if the hospital has submitted its claim within three months of the date of service and requiring RACs to provide 30 days for hospitals to discuss denied claims in an effort to avoid appeals. In addition, AHA worked to limit RACs’ ability to conduct patient status reviews. CMS has recently significantly reduced the amount of claims RACs can audit per hospital from 2% of a hospital’s Medicare claims volume to 0.5%.
- **Providing Consumers with Meaningful Quality Information** – AHA provided feedback to CMS to help shape its new five-star rating system for its consumer-facing Compare websites, arguing for more measures that demonstrate quality of care for patients and less burdensome reporting requirements for providers. AHA continues to promote a streamlined approach to quality measurement through the implementation in the Institute of Medicine’s recent Vital Signs report.

AHA continues to work with CMS to shape its new bundling program for hips and knees, and with HRSA to shape its final mega-guidance for the 340B program regarding the definition of an eligible patient; definition of covered outpatient drug; and the effective date, among other issues. Through our 340B Advocacy Alliance, we continue to work to ensure Congress does not narrow the program.

Protecting Fair Reimbursement

Any time Congress struggles with a fiscal crisis, funding to protect patient care is at risk. This year, as Congress looked for savings to fund the Medicare physician payment fix, the 21st Century Cures Act, trade legislation, the budget agreement and more, AHA and you – our grassroots advocates – helped:

- Maintain graduate medical education funding
- Prevent harmful changes to the Critical Access Hospital program
- Prevent further restrictions on states’ use of Medicaid provider assessments
- Prevent harmful restrictions on the 340B program

In addition, the Medicare physician fix legislation prevented a 21% payment cut. It also included extensions of the Medicare-dependent Hospital Program, low-volume adjustment and ambulance add-on payments. In addition, it delayed scheduled Medicaid DSH cuts until FY 2018 and prevented CMS from implementing a 0.55% behavioral coding offset. AHA also helped halt proposals to loosen restrictions on physician-owned hospitals.

Although we were disappointed that the budget package included restrictions on payments to new provider-based outpatient departments, we were able to protect existing arrangements and provide exceptions for services provided in dedicated emergency departments. We will continue to work with Congress to make refinements and provide additional flexibility for facilities under development.

We also worked with CMS on implementing the IMPACT Act, expanding the number of cases that qualify for the standard long-term care hospital payment rate, and lessening proposed cuts to Medicare Advantage.