



## Teaching Hospitals



**Teaching hospitals fulfill critical social missions**, including educating and training future medical professionals; conducting state-of-the-art research; caring for the poor and uninsured; and standing ready to provide highly specialized clinical care to the most severely ill and injured patients.

### Related Resources

[AHA Advocacy Alliances](#)

[AHA Physician Leadership Forum](#)

[AHA Section for Metropolitan Hospitals](#)

[Community Connections](#)

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

Working for Teaching Hospitals

Engaging Teaching Hospital Leaders

Providing Key Resources

## Working for Teaching Hospitals

*Payment shortfalls, workforce shortages and outdated and duplicative regulations increase the burden on teaching hospitals and draw much-needed resources away from patient care. AHA has worked to stave off cuts to funding for graduate medical education (GME) and demonstrate 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.

- **Opposed GME Cuts and Worked to Expand Residency Training Slots.** AHA opposed proposals that would alter the graduate medical education (GME) financing structure in a way that would reduce direct graduate medical education (DGME) or indirect medical education (IME) payments to teaching hospitals. Cuts to GME funding would jeopardize the ability of teaching hospitals to train the next generation of physicians and reductions in the IME adjustment would directly threaten the financial stability of teaching hospitals. In July, the AHA urged the Health Subcommittee of the Committee on Ways and Means to end the 18-year freeze on the number of physician training positions that Medicare funds and to support the creation of at least 15,000 new residency positions.
- **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](http://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.

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

**FACT:** For more than 20 years, the 340B Drug Pricing Program has provided financial help for safety-net hospitals to manage drug procurement programs. Section 340B of the Public Health Service Act requires drug manufacturers to provide a discount to health care providers for the purchase of certain anti-infective products. This, in turn, allows hospitals to provide needed patient care and reduce the price of inpatient pharmaceuticals for the most vulnerable patients.

**FICTION:** Despite the program's success, some critics have questioned its structure and reporting. In one instance, a report by a former AHA board member alleged that the program is not working as intended. However, the program has been successful in reducing the cost of drugs for safety-net hospitals and improving patient care.

**FACT:** The 340B program accounts for the only two percent of the 2015 total inpatient drug purchases made in the U.S. through the Affordable Care Act (ACA). Since its inception in 1992, the 340B program has allowed safety-net hospitals to improve health care access and reduce the financial and operational burden of high-cost drugs.

**FICTION:** The 340B program has not the way from the original intent. The program was established to support a variety of programs that are improving patient quality of care for the most vulnerable and underserved populations. It is not intended to be a source of profit for hospitals or to be used for other purposes.

**FACT:** The 340B program is still operating in the manner Congress intended it to be. The program has been successful in reducing the cost of drugs for safety-net hospitals and improving patient care. The program has also been successful in providing a source of revenue for safety-net hospitals.

**FICTION:** The 340B program is not intended to be a source of revenue for safety-net hospitals. The program is intended to provide a source of revenue for safety-net hospitals to improve patient care and reduce the financial and operational burden of high-cost drugs.

- **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.

- **Clarified Foundation Health Plan Premium Payments.** AHA sought and received legal clarification from HHS confirming that payments from private, not-for-profit foundations to qualified health plans on behalf of individuals who enrolled in coverage via the Health Insurance Marketplaces were not prohibited.
- **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.
- **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](http://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](http://www.aha.org/value).



## Engaging Teaching Hospital Leaders

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

- **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.
- **[AHA Constituency Section for Metropolitan Hospitals](#):** The AHA Constituency Section for Metropolitan Hospitals has almost 1,000 members from across the country and is composed of CEOs from teaching, public, metropolitan/urban and suburban hospitals. The Section provides forums linking members with shared interests and missions to advise AHA on policy and advocacy activities and to discuss issues of great importance to metropolitan and teaching hospitals and the field as a whole. These efforts are led by the Metropolitan Hospitals Governing Council, which meets at least three times a year. Valuable opportunities also are provided for teaching hospital leaders to interact and network with one another through special member conference calls and meetings.
- **[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. The [Advocacy 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.
- **Executive Roundtable for Hospitals with Health Plans.** Health care system and hospital CEOs and their teams meet regularly to provide their guidance to AHA on the policy agenda for members with health plans, as well as specific and time-sensitive issues impacting providers and insurers. The roundtable is chaired by Jim Hinton, president and CEO of Presbyterian Healthcare Services, and AHA immediate-past chairman.



- **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 Teaching Hospitals

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

- **[Teaching Hospitals: Preparing Tomorrow's Physicians Today](#).** This report is part of an AHA *TrendWatch* series that highlights the latest trends affecting hospitals and the health care system and informs the policy-making process. This June 2015 publication looked at current issues impacting teaching hospitals.
- **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.
- **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](http://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 issued [goals 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](http://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](http://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.
- **RACTrac.** The AHA RACTrac 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 RACTrac 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](http://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](http://www.hfma.org).
- **AHA Resource Center.** Highly trained information specialists assist members in accessing timely and relevant health services articles and data.