



American Hospital
Association®

2017 Advocacy Agenda





Advancing Health in America

2017 Advocacy Agenda

Hospitals and health systems are transforming the way health care is delivered in their communities, working with other providers and community leaders to build a continuum of care to make sure every individual gets the right care, at the right time, in the right setting. In order to continue this transformation, and to provide patients with the access to care they need and expect, hospitals need a supportive and modernized public policy environment. In 2017, the American Hospital Association (AHA) is working with Congress, the Administration, the courts and other agencies to uphold our strategic commitments to:

- 1. Access** – *The AHA is committed to ensuring all Americans have affordable and equitable health, behavioral and social services.*
- 2. Value** – *The AHA is committed to ensuring hospitals and health systems provide the best care that adds value to patients' lives.*
- 3. Partners** – *The AHA is committed to embracing the diversity of individuals, and serving as partners in their health.*
- 4. Well-being** – *The AHA is committed to focusing on patient well-being in partnership with community resources.*
- 5. Coordination** – *The AHA is committed to providing seamless care propelled by teams, technology, innovation and data.*



1. ACCESS: ACCESS TO AFFORDABLE, EQUITABLE HEALTH, BEHAVIORAL AND SOCIAL SERVICES

- **The Affordable Care Act (ACA).** Congress continues to debate measures to repeal and replace parts of the ACA. The current bill, the American Health Care Act (AHCA) (H.R. 1628), would halt the ACA's employer and individual mandates to purchase health coverage and replace the law's means-tested advance premium tax credits and cost-sharing reductions with age-based tax credits that phase out for higher-income individuals. The bill also would end the enhanced Medicaid federal funding for future expansion populations, beginning in 2020, and transition the program to a per capita cap funding model. The package does not restore the hospital market-basket reductions used to help fund the ACA coverage expansions. The non-partisan Congressional Budget Office (CBO) estimated that the bill would result in 24 million fewer people covered in 2026, and a reduction of \$839 billion in funding for the Medicaid program over 10 years.

AHA cannot support the AHCA in its current form and continues to urge legislators to protect affordable coverage for as many Americans as possible, particularly the 20 million Americans who have gained coverage, including millions of our most vulnerable citizens — children, the disabled, those with pre-existing conditions and the elderly. America's hospitals believe that we must maintain coverage for all individuals currently receiving benefits. The ACA should not be repealed without a simultaneous replacement guaranteeing adequate coverage. If that does not occur, then the hospital and health system payment reductions that were used to fund coverage expansions must be restored, so that we have the resources to help care for the increased number of uninsured. In addition, Medicaid restructuring — in the form of block grants and per capita caps — should not be used as a vehicle to make budget cuts in an already under-funded program. Additional flexibility to the states can be provided through increased use of waivers, provided they are accompanied by safeguards that ensure sufficient funding for adequate coverage. And expansion and non-expansion states must be treated equitably. Any further Medicare and Medicaid reductions in payments for hospital and health system services should be avoided to ensure that our patients and communities continue to have access to high-quality care. In addition, efforts must continue to transform the delivery system away from fee-for-service (FFS) and toward fee-for-value using coordinated care and integrated delivery mechanisms.

- **Health Insurance Marketplaces.** More than 12 million consumers purchase coverage through state and federal Health Insurance Marketplaces. However, in some regions of the country, the marketplaces are struggling to attract robust insurer and consumer participation, and insurer exits put some consumers at risk. Without marketplace plans, consumers cannot access the federal premium tax credits and cost-sharing reductions that help make coverage affordable. A number of challenges contribute to marketplace instability, including ongoing

insurer financial losses as a result of early mispricing of plans, disproportionate enrollment among high-need individuals, uncertainty around the availability of funds for the cost-sharing reduction subsidies, and expiration of the reinsurance program at the end of 2016.

AHA will advocate for a set of policies to attract both insurer and consumer participation in the marketplaces, such as fully funding the cost-sharing reductions and continuing a reinsurance mechanism. Such changes must retain critical consumer protections, including robust network adequacy requirements and coverage of the 10 essential health benefits, to facilitate consumer access to care.

- **Insurance Market Consumer Protections.** Federal law currently ensures consumer access to robust coverage, including through rules related to minimum benefit packages, actuarial value and cost-sharing limits. In addition, in order to increase the affordability of coverage and prevent individuals from being priced out of the market, insurers must price plans based on the aggregate risk they experience across all of a plan's enrollees instead of medically underwriting each individual (community rating). Insurers also are prohibited from declining coverage to any individual based on his or her medical history or other assessment of individual risk. These protections are currently under debate as some policymakers look for opportunities to further decrease the cost of coverage.

While the AHA fully supports increasing the affordability of coverage, we will urge Congress and the Administration to maintain critical consumer protections, such as the essential health benefits. Coverage must be meaningful in order to ensure patient access to care.

- **Alternative Coverage Options.** Given the uncertainty around the Health Insurance Marketplaces, some policymakers are exploring alternative coverage options, including reinstating state high-risk pools and easing the sale of insurance products across state lines. We have concerns that these options may distort insurance markets while not solving the underlying challenges of the marketplaces. High-risk pools require significant funding and, in the past, have had to rely on high premiums and cost sharing, wait lists and other strategies to reduce costs. The sale of insurance across state lines raises a number of concerns, including the potential loss of consumer and provider protections in instances where a plan is licensed in another state.

AHA will continue to advocate for solutions that improve coverage programs by addressing underlying challenges, not approaches that may bring unintended negative consequences for consumers and providers.

- **Medicaid Expansion.** More than 11 million individuals have gained health coverage as a result of 31 states and the District of Columbia expanding their Medicaid programs. In 2016, the federal government spent more than \$76 billion on services for this expansion population. The benefits of Medicaid expansion

for individuals, communities and states has been well documented. For example, expansion states have realized a greater reduction in the number of uninsured, as well as increased access to primary care and increased rates of diagnosis of chronic conditions for the new Medicaid enrollees. State economies have benefitted as well. States that have expanded Medicaid consistently show that expansion generates savings and revenue.

AHA supports efforts to encourage every state to expand Medicaid coverage, whether through increased federal financial support or state-specific Medicaid waivers.

- **Medicaid Waivers.** Medicaid demonstration waivers have long been available to states as a way to test new approaches. Over the years, states have used waivers for many purposes, including to expand coverage, promote delivery system reform, alter benefits and cost sharing, modify provider payments, and quickly address coverage needs during an emergency (e.g., Hurricane Katrina, spread of the Zika virus). In a March letter to the nation’s Governors, Health and Human Services (HHS) Secretary Tom Price and Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma wrote: “We commit to ushering in a new era for the federal and state Medicaid partnership where states have more freedom to design programs that meet the spectrum of diverse needs of their Medicaid population.”

AHA believes that the expanded use of waivers is a key component of any substantial Medicaid reform – they can enable state-driven health care delivery reforms and help ensure continued access to affordable coverage for beneficiaries and adequate payment for the providers that serve them. The current Medicaid waiver process, however, needs to be reformed with a streamlined process that must include stakeholder engagement to ensure state-driven health care innovation.

- **Medicaid Provider Assessments.** The Medicaid provider assessment program has allowed state governments to expand coverage and maintain patient access to health services to avoid additional provider payment cuts. Yet, some have called for limiting states’ ability to use assessments as a financing tool.

AHA continues to urge policymakers to reject options that limit states’ ability to help fund their Medicaid programs using provider assessments.

- **Medicaid DSH and Non-DSH Supplemental Payments.** Medicaid hospital payment programs, such as Medicaid disproportionate share hospital (DSH) and non-DSH supplemental payment programs, are critical to our nation’s hospitals. Nearly 44 percent of all state FFS Medicaid payments to hospitals are derived from these supplemental payment programs. The ACA included cuts to Medicaid DSH payments, based on the reasoning that hospitals would care for fewer uninsured patients as health coverage is expanded. This expanded coverage, however, has not been fully realized due to affordability concerns in the insurance markets and the decision of 19 states to not expand their Medicaid programs. AHA has been

successful in delaying the Medicaid DSH cuts until fiscal year (FY) 2018. However, barring any further delay, \$2 billion in Medicaid DSH cuts will begin Oct. 1, 2017. In addition, states have increasingly turned to non-DSH supplemental payments in the form of upper payment limit (UPL) payments to support hospitals. Yet, CMS recently issued policies that limit state Medicaid programs' ability to use UPL payments in a managed care setting. Limiting these supplemental pass-through payments could adversely affect hospitals that are dependent on these supplemental payments.

AHA will urge policymakers to refrain from making further cuts to Medicaid DSH and urges CMS not to restrict non-DSH supplemental payment programs in the managed care or FFS settings.

- **CHIP Reauthorization.** Medicaid and the Children's Health Insurance Program (CHIP) are responsible for reducing the number of uninsured children to historically low levels. Yet, the future of the CHIP program remains uncertain. Specifically, while CHIP eligibility standards have been extended through 2019, CHIP funding has been extended only through FY 2017. The Medicaid and CHIP Payment and Access Commission has projected that between 1 and 2 million children are at risk for losing coverage if CHIP funding is not extended.

AHA urges Congress to extend the funding for CHIP to ensure critical health coverage for vulnerable children.

- **Medicare Advantage (MA).** Today, almost a third of all Medicare beneficiaries receive their benefits through a private MA plan, and this number is expected to continue to grow. Some hospitals and health systems have either built insurance capabilities or have partnered with a commercial insurer to offer an MA plan. As the federal government looks to reduce the annual increase in health care spending, MA has been a target for rate cuts. Adequate rates are necessary to ensure fair payments to contract providers and to provide consumers with a robust set of high-quality plan options. In addition, AHA supports additional program flexibility to enable MA plans to tailor benefits and cost sharing to meet the needs of the populations they serve.

AHA will advocate against any cuts to MA payment rates, and for flexibilities in benefit and cost-sharing structures that facilitate beneficiary access to the highest quality care.

- **Medicare DSH.** For several years, CMS has discussed using the cost report's Worksheet S-10 data on hospital charity care and bad debt to determine the amount of uncompensated care each hospital provides, in place of the current DSH formula of Medicaid and Medicare Supplemental Security Income (SSI) days. In the recently issued inpatient prospective payment system (PPS) proposed rule, the agency proposes to, in FY 2018, begin a three-year phase in of incorporating hospitals' Worksheet S-10 data into the methodology for determining uncompensated

care DSH payments. It also proposes that, beginning in FY 2018, uncompensated care costs would be defined to include charity care and non-Medicare bad debt. Finally, CMS states that it has developed a process for auditing the S-10 data, but that audited data will not be available for use until FY 2021.

AHA remains concerned about CMS’s proposal to use the “Worksheet S-10” data without taking sufficient action to ensure the accuracy, consistency and completeness of these data prior to their use. We have communicated with the agency on the steps that should be taken to improve the quality of these data and thereby help ensure fair payment for hospitals treating vulnerable communities. We will continue to advocate that the agency adopt these changes, as well as a broad definition of uncompensated care that includes Medicaid shortfalls and discounts to the uninsured.

- **Medicare Bad Debt.** In recent years, Congress has reduced payments that reimburse hospitals for a portion of the debt incurred by Medicare beneficiaries, particularly those with low incomes. However, reducing or eliminating this reimbursement disproportionately affects hospitals that treat high numbers of low-income Medicare beneficiaries – safety-net hospitals and rural hospitals. It leaves safety-net hospitals with less ability to serve low-income Medicare beneficiaries, who may not be able to afford the cost-sharing requirements, and puts rural hospitals and the patients they serve under severe stress, as their small size leaves them with more limited cash flow and less of an ability to absorb such losses.

AHA will urge Congress to refrain from further cuts to Medicare bad debt.

- **Post-acute Care Payments.** The post-acute care field is undergoing a major transformation. For example, inpatient rehabilitation facilities (IRFs) have dramatically reduced their overall volume and steadily increased the medical complexity of IRF patients. Long-term care hospitals (LTCHs) are adjusting to the new statutorily-mandated “site-neutral” payment system, which began in October 2015. When fully implemented, almost one out of every two cases will receive a site-neutral payment that is 54 percent less, on average, than the full LTCH payment. In addition, the movement toward alternative payment models, including the implementation of mandatory bundled payments for joint replacement cases, is bringing a further round of changes to post-acute care. Finally, the IMPACT Act of 2014 required the Medicare Payment Advisory Commission (MedPAC), CMS and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to make recommendations on a new, unified post-acute care payment system to replace the current siloed payment systems for LTCHs, IRFs, skilled nursing facilities and home health agencies. If Congress were to authorize implementation of such a payment system, it would bring further volatility to the post-acute care field and their patients.

AHA urges Congress to reject further payment cuts to post-acute care providers and instead provide additional regulatory relief to those participating in alternative payment models. In addition, as LTCH site-neutral payments continue to be

implemented, it is important to waive regulations that exist solely for the prior payment structure. Finally, AHA will advocate with policymakers designing the new unified post-acute care payment system to ensure that it is accurate and covers the cost of the full continuum of medically necessary post-acute care services.

- **Site-neutral Payments.** Section 603 of the Bipartisan Budget Act (BiBA) of 2015 enacted site-neutral payments for new, off campus provider-based hospital outpatient departments (HOPDs), despite different cost structures between HOPDs and physician offices. Subsequently, with AHA’s support, the 21st Century Cures Act established exceptions for certain off-campus HOPDs that were under construction at the time BiBA was passed in November 2015. Some, including MedPAC, have advocated for even greater use of such “site-neutral” payments.

AHA will urge Congress to reject calls for any additional site-neutral payment policies for HOPDs. We also urge CMS to implement its policies for 2018 and beyond in the most favorable and flexible manner possible.

- **Behavioral Health.** Repealing and replacing the ACA could jeopardize access to behavioral health treatment for millions of people. But, even if the ACA is preserved, AHA is concerned about persistent gaps in access to behavioral health services; the shortage of mental health professionals in many communities; the urgent need to address opioid addiction and its repercussions; and the need to truly establish parity for mental health care.

AHA urges Congress to protect behavioral health coverage; improve access to services, including by increasing funding and addressing workforce shortages; promote policies that better integrate mental and physical health; and support better information exchange. Additionally, AHA supports removing barriers to mental health treatment, such as amending the Medicaid Institution for Mental Disease exclusion, eliminating the Medicare 190-day lifetime limit on inpatient psychiatric treatment, and providing funding to implement the Comprehensive Addiction and Recovery Act to help stop the opioid crisis in America.

- **Access to Care in Vulnerable Communities.** In 2016, an AHA task force released its report on *Ensuring Access to Care in Vulnerable Communities*, which offers hospital and health system leaders nine innovative ways to preserve access to essential health services in vulnerable communities. These nine strategies are:
 - Addressing the social determinants of health
 - Global budgets
 - Inpatient/outpatient transformation strategy
 - Emergency medical centers
 - Urgent care centers
 - Virtual care strategy
 - Frontier health system

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- Rural hospital-health clinic strategy
 - Indian health service strategy

Successful implementation of these emerging strategies by vulnerable communities is dependent on numerous public policy changes. As such, AHA is developing the specific legislative and regulatory changes that are necessary to enable their implementation. We are advocating that policymakers make such changes a priority so that hospitals and health systems can better ensure access to care in vulnerable urban and rural communities.

- **Medicare Rural Payment Extensions.** Medicare rules include a number of important payment policies that ensure financial stability for hospitals that primarily treat Medicare patients, account for low patient volumes, and address the high costs of providing ambulance services in rural areas. Without legislative action, these programs will expire in 2017:
 - Medicare-dependent hospitals (MDH) (expires Sept. 30)
 - Enhanced low-volume adjustment (expires Sept. 30)
 - Increased payments for ground ambulance services (expires Dec. 31)

AHA urges Congress to make these important programs permanent and extend regulatory relief by passing the Rural Hospital Access Act (S. 872/H.R. 1955) and the Medicare Ambulance Access, Fraud Prevention and Reform Act.

- **CAH Payment Policies.** Some policymakers are calling for dramatic reductions to the critical access hospital (CAH) program, including the elimination of CAH designation based on mileage between CAHs and other hospitals, and removal of CAH “necessary provider” exemptions from the distance requirement.

AHA urges Congress to reject misguided proposals to change the CAH program. In addition, AHA encourages the Administration to finalize a provision directing Medicare auditors not to enforce the physician certification piece of the 96-hour Rule as a condition of payment.

- **Supervision of Outpatient Therapeutic Services.** In the 2009 outpatient PPS final rule, CMS mandated a new policy for “direct supervision” of outpatient therapeutic services that hospitals and physicians recognized as a burdensome and unnecessary policy change. At the urging of AHA and others, CMS delayed enforcement of the policy through 2016 for CAHs and small and rural PPS hospitals. Since Jan. 1, 2017, CMS has permitted its contractors to enforce the direct supervision policy in all hospitals and CAHs.

AHA urges Congress to pass a permanent extension of the enforcement moratorium on the direct supervision policy for CAHs and small and rural hospitals to ensure patients continue to have access to these services via the Rural Hospital Regulatory Relief Act of 2017 (H.R. 741, S. 243).

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- **Veterans Health.** The Veterans Choice Program is a temporary benefit allowing some veterans to receive primary health care and specialty services from community health care providers, including hospitals and health systems rather than waiting for a Veterans Health Administration (VHA) appointment or traveling to a VHA facility. It was authorized under the Veterans Access, Choice, and Accountability Act of 2014 and provides \$10 billion for non-VHA medical care to eligible veterans. The Choice Program was slated to sunset in August 2017. Congress recently passed a bill that would eliminate the August sunset date for the program and allow the VHA to spend the nearly \$1 billion in remaining program funding. While the Choice Program has been helpful in providing access to health care services to some veterans, hospitals and health systems consistently find it difficult to obtain timely payment from the VHA and its contractors.

AHA urges Congress and the Administration to work with hospitals and health systems throughout the country as it considers the next generation of a comprehensive community care plan for veterans. We believe a strong partnership between community providers and the VHA is essential to ensure our nation's veterans receive the health care they need and deserve. AHA will work with the government as it considers the Commission on Care's recommendations to develop a national delivery strategy, including criteria and standards for creating a potential "VHA Care System," comprising of high-performing, integrated, community-based health care networks, including VHA providers, Department of Defense providers, and community providers and facilities.



2. VALUE: THE BEST CARE THAT ADDS VALUE TO LIVES

- **Hospital Star Ratings.** Despite objections from a majority of Congress, CMS published a set of deeply flawed hospital star ratings on its website in 2016. While hospitals have long supported sharing quality information with consumers, the hospital star ratings were broadly criticized by quality experts and Congress as being inaccurate and misleading to consumers seeking to know which hospitals were more likely to provide safer, higher-quality care.

AHA urges the Administration to suspend the faulty star ratings from the Hospital Compare website.

- **Streamlining Quality Measurement.** Improvements in quality and patient safety are accelerating, but the ever-increasing number of conflicting, overlapping measures in Medicare reporting and pay-for-performance programs divert time and resources away from what matters the most – improving care. Data collection and reporting activities would be more valuable if federal agencies, private payers and others requiring quality data agreed on a manageable list of high-priority aspects of care. Then, providers could use a small and critically important set of measures to track and report on progress toward improving the care delivered and the outcomes for patients.

AHA is working with the Administration and other stakeholders to streamline and prioritize quality reporting requirements so that they focus on “measures that matter” most to improving health and outcomes.

- **Patient Safety.** Hospitals and other health care organizations recognize their responsibility to ensure patients receive high-quality care during the course of their treatment. AHA and its member organizations have achieved important and meaningful improvements through rigorous adoption of evidence-based processes that have been shown to prevent errors. But more must be done. Further, the adoption of new technologies, procedures and drugs can advance outcomes for patients, but also may result in additional challenges.

AHA urges continued investment in research to develop new knowledge and strategies that inform hospital efforts to deliver safe and effective care.

- **Sociodemographic Adjustment.** A body of research demonstrates that readmissions are higher in communities that are economically disadvantaged. For this reason, the 21st Century Cures Act requires CMS to implement sociodemographic adjustment in the hospital readmissions penalty program starting in FY 2019. At the same time, a recent series of reports from the National Academy of Medicine shows that other outcome measures, such as 30-day mortality rates and measures of efficiency and patient experience, are similarly impacted by

sociodemographic factors. Moreover, a report from ASPE shows that providers caring for large numbers of poorer patients are more likely to perform worse on a wide range of hospital, physician and post-acute care pay-for-performance programs.

AHA will urge CMS to ensure its implementation of sociodemographic adjustment in the hospital readmissions penalty program is done in a transparent and fair manner. AHA also urges the Administration to incorporate sociodemographic adjustment into its other quality measurement and pay-for-performance programs where necessary and appropriate.

- **Quality Measurement for New Payment Systems.** As CMS and other entities develop new payment strategies that link quality performance or value to payment, it is increasingly important that scientifically valid measures are used to assess the quality and safety of the providers involved in care and their impact on patient outcomes.

AHA will work with CMS, other payers, the National Academy of Medicine, the National Quality Forum and the Measure Applications Partnership to identify meaningful and valid measures for use in emerging payment programs, and will collaborate with other organizations to assess whether the measures are contributing toward intended improvements or having unintended consequences.

- **Post-acute Care Value-based Purchasing.** In an attempt to accelerate improvement in post-acute care by tying payment to performance, legislation was introduced in the last Congress to create a unified value-based purchasing program. Specifically, the legislation would establish a shared incentive pool through reductions in base payment rates across the four post-acute care settings, and then score providers based on their performance on cost and quality metrics. Providers of all types would then be ranked against each other for the opportunity to gain back all, some, or none of the payment reduction in the form of incentive payments. Importantly, the legislation was not budget neutral, the required quality measures were not adjusted for sociodemographic factors, and the structure of the program was needlessly complex.

AHA will urge Congress to consider a more equitable and less complex value-based purchasing program.

- **Drug Prices.** Spending on prescription drugs continues to rise rapidly due to significant increases in drug prices. While brand-name and specialty drugs have seen particularly large price increases, the problem is universal, with the cost of some common generic drugs increasing dramatically as well. These high prices challenge patients' and providers' ability to access drug therapies.

AHA urges Congress to ensure fair and sustainable drug pricing through a number of policy proposals intended to spur competition, develop value-based pricing mechanisms, increase transparency, and promote provider and

patient access to lower-cost medications. These policies include: fast-track generic applications; deny patents for “ever-greened” products; increase oversight and deem presumptively illegal “pay-for-delay” tactics; limit orphan drug incentives to true orphan drugs; disallow co-pay assistance cards; increase disclosure requirements related to drug pricing, research and development; allow providers and patients to reimpose certain drugs; require mandatory, inflation-based rebates for Medicare drugs; implement stricter requirements on direct-to-consumer advertising; remove tax incentives for drug promotion activities; test changes to the federally-funded Part D reinsurance program; develop Medicare-negotiated value-based payment arrangements; and vary patient cost-sharing for certain drugs based on demonstrated value.

- **340B Drug Pricing Program.** For 25 years, the 340B program has provided assistance to safety-net hospitals by allowing them to stretch limited federal resources to reduce the price of outpatient pharmaceuticals for patients and expand health services. It requires pharmaceutical manufacturers participating in Medicaid to sell many outpatient drugs at discounted prices to health care organizations that care for large numbers of uninsured and low-income patients. Eligible hospitals use 340B savings to provide, among other services, local access to drugs and treatments for cancer patients, clinical pharmacy services, community outreach programs, free vaccinations and transportation to patients for follow-up appointments. However, some policymakers and stakeholders want to scale back the program or significantly reduce its benefits.

AHA urges Congress to oppose cuts to the 340B program and will work with the Health Resources and Services Administration (HRSA) to protect patient access to the program.

- **Medicare Physician Payment.** The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 created a new physician payment and performance measurement program that includes incentives for participation in advanced payment models that lead to more integrated, better coordinated care. CMS began limited implementation of the new payment program Jan. 1, 2017.

AHA will urge CMS to continue to implement the new physician payment program in a flexible manner that minimizes unnecessary burden on clinicians. This will include advocating for a reporting option that allows hospital-based clinicians to use their hospital’s quality and cost measure results in the Merit-based Incentive Payment System (MIPS). In addition, AHA will advocate for additional advanced alternative payment models that will reward clinicians who partner with hospitals to reduce cost and improve quality. AHA also will continue to educate members on the new payment program as implementation continues.

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- **Physician-owned Hospitals.** Some members of Congress propose eliminating Medicare’s prohibition on physician self-referral to new physician-owned hospitals and restrictions on the growth of existing hospitals. Legislation now before Congress would allow many more physician-owned hospitals to open and permit unfettered growth of existing physician-owned hospitals. If enacted, the bill would lead to cherry-picking of healthier, better-insured patients and jeopardize access to critical services in many communities.

AHA urges Congress to: maintain current law; preserve the ban on physician self-referral to new physician-owned hospitals; and retain restrictions on the growth of existing physician-owned hospitals.

- **Medical Liability Reform.** The high costs associated with the current medical liability system harm not only 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. Legislation currently under consideration by Congress – H.R. 1215, the Protecting Access to Care Act of 2017 – would cap non-economic damages and attorneys’ contingency fees, among other reforms. The CBO found that these reforms could save \$50 billion over 10 years.

The AHA will continue to advocate for comprehensive reforms to the medical liability system, including caps on non-economic damages and allowing courts to limit attorneys’ contingency fees.

- **Recovery Audit Contractors (RACs).** In 2015, CMS announced several changes intended to reduce the significant burden hospitals bear as a result of RAC audits. For example, Quality Improvement Organizations, rather than RACs, now have primary responsibility for auditing the appropriateness of inpatient admissions under the “two-midnight” inpatient admissions criteria. In addition, CMS lowered the percentage of hospital Medicare claims that RACs may audit. Despite these incremental improvements, more reform is needed to address the contingency fee payment structure that continues to reward RACs for inappropriate denials.

AHA urges Congress to eliminate the RAC contingency fee structure and instead direct CMS to pay RACs a flat fee, as every other Medicare contractor is paid. In addition, CMS should rationalize payments to RACs by lowering payments for poor RAC performance due to high rates of incorrect denials.



3. PARTNERS: EMBRACE DIVERSITY OF INDIVIDUALS AND SERVE AS PARTNERS IN THEIR HEALTH

- **Health Disparities.** Research has shown that individuals of color, of various ethnic backgrounds, religions, sexual orientation, or with limited English proficiency have less access to care, receive different care and often have worse health than those who are white. An individual's health is influenced by many different factors, including inherited traits, the health care received, individual habits and choices, and different community and environmental factors. AHA and its members strive to help all individuals achieve their highest potential for health. In particular, AHA is focusing on ensuring that everyone in the U.S. has access to the care they need when they need it, and that it is safely and efficiently delivered. We also are collaborating with other key stakeholders in communities across the nation to promote better health in every community, especially where currently disparities in health outcomes exist.

AHA supports efforts to reduce health care disparities. This includes helping to improve measurement to identify disparities, encouraging adoption of the #123forEquity campaign to eliminate disparities, and promoting efforts to share practices that have successfully helped to reduce or eliminate disparities.

- **Medical Education and Training.** Medicare graduate medical education (GME) funding is critical to maintaining our nation's physician workforce. However, such funding is both insufficient in its current scope and under threat of further reductions. The Balanced Budget Act (BBA) of 1997 imposed caps on the number of residents for which each teaching hospital is eligible to receive Medicare direct and indirect medical education reimbursement. These caps have generally been adjusted only as a result of certain limited and one-time adjustments and are a major barrier to reducing the nation's significant physician shortage. In addition, the BBA reduced over time the additional payment that teaching hospitals receive for each Medicare discharge to reflect the higher patient care costs of teaching hospitals relative to non-teaching hospitals, known as the indirect medical education adjustment (IME). Republican leaders of the House Committee on Ways and Means previously introduced legislation that would reimburse IME costs through lump-sum payments rather than for each discharge, beginning with cost-reporting periods ending during or after FY 2019.

AHA urges Congress to reject reductions in Medicare funding for indirect medical education and direct GME. Additionally, we urge Congress to pass the Resident Physician Shortage Reduction Act to increase the number of Medicare-funded residency positions.



4. WELL-BEING: FOCUS ON PATIENT WELL-BEING IN PARTNERSHIP WITH COMMUNITY RESOURCES

- **Advanced Illness Management.** The health care landscape is being reshaped to support improved coordination across the care continuum, and this must include providers, patients and families navigating advanced illness management. Specific areas of focus include coordination of curative and palliative treatment across all care providers and settings; shared decision-making among patients, family members and providers; and expanded palliative care knowledge for providers caring for individuals with serious advanced illness. CMS created a benefit to support advanced care planning, but more needs to be done. Advance directives should be readily accessible and verified as current. Additional provider training and tools are needed to engage in conversations that align with the patient's stated goals, values and informed preferences. New pilots or models of care should be expanded to incorporate advanced illness management in their overall goal to improve quality, the patient care experience and cost outcomes for Medicare beneficiaries.

AHA continues to urge Congress and HHS to support efforts that incorporate advanced illness management in the provision of health care, such as education on the new advanced care planning benefit and incorporation of advanced illness management in new models of care.

- **Tax-exempt Status.** According to the Internal Revenue Service in its most recent report to Congress, hospitals provided \$65.4 billion in community benefit — or 9.84 percent of expenses — in 2012. A report from Ernst & Young for the AHA covering the same period and all of the community benefits provided, found that hospitals spent an average 12.3 percent of total expenses. In comparison, the most recent estimate of the value of tax exemption (federal, state and local) was only \$24.6 billion in 2011. Nevertheless, some policymakers at the federal, state and local levels have questioned whether community benefits provided by non-profit hospitals are commensurate with the tax benefits of tax-exempt status.

AHA will continue to collect information from members on community benefit, including Schedule Hs. In addition, AHA has commissioned a report comparing the value of tax exemptions and hospitals' community benefit using more current data. As Congress begins to debate federal tax reform, this information will be essential to demonstrate the positive return communities receive from hospital tax exemption. In addition, we will continue to work with the state hospital associations to combat efforts to limit tax benefits available to nonprofit hospitals.



5. COORDINATION: SEAMLESS CARE PROPELLED BY TEAMS, TECHNOLOGY, INNOVATION AND DATA

- **New Models of Care.** Over the past several years, CMS has created a number of programs to test new approaches to payment and care delivery. These efforts, which largely have been voluntary for providers, include multiple accountable care organization (ACO) initiatives, advanced primary care models and episode-based payments such as the Bundled Payments for Care Improvement (BPCI) program. However, CMS recently finalized two mandatory bundled payment models that hold acute-care hospitals financially accountable for quality and costs for the entire episode of care following targeted procedures. The Comprehensive Care for Joint Replacement (CJR) model targeting hip and knee replacements has been implemented in 67 geographic areas across the country and was recently expanded to include (beginning Oct. 1) surgical treatments for hip and femur fractures. A model targeting heart attack and cardiac bypass surgery services also begins Oct. 1 and is being implemented in 98 geographic areas across the country.

AHA is actively monitoring CMS's new payment and delivery models and continuously provides input to CMS on how to improve their success. However, while it is important to offer opportunities to explore new models, AHA urges the Administration to make any future programs voluntary. Hospitals should not be forced to bear the expense of participation in complicated new programs if they do not believe they will benefit the patients they serve.

- **Telehealth.** The use of telehealth has grown in recent years, to the point where more than half of U.S. hospitals connect with patients and consulting practitioners through the use of video and other technology. However, coverage, payment and other policy issues prevent full use of telehealth, including remote patient monitoring and other technologies. Medicare policy is particularly challenging, as it limits the geographic and practice settings where beneficiaries may receive services, as well as the types of services that may be provided via telehealth and the types of technology that may be used. Access to broadband services and state-level policy issues, such as licensure, also limit the ability to use telehealth.

AHA urges Congress to expand Medicare coverage and payment for telehealth. AHA also urges the Administration to include telehealth waivers in all new care models, and adopt a more flexible approach to adding new telehealth services to Medicare. We will continue to work with the state hospital associations to address state-level issues, including licensure and parity in coverage and reimbursement for telehealth services.

- **EHR Incentive Program.** America's hospitals are strongly committed to the adoption of electronic health records (EHRs) and the transition to an EHR-enabled health system is well underway. CMS has provided welcome short-term relief by finalizing a 90-day reporting period in 2017 and proposing a 90-day

reporting period in 2018. However, CMS has not yet provided relief from rules that raise the bar on meaningful use requirements in Stage 3 required in 2018. These rules contain provisions that are challenging, if not impossible, to meet and require use of immature technology standards.

AHA urges CMS to cancel Stage 3 of meaningful use by removing the 2018 start date from the regulation, and gather input from stakeholders on ways to further reduce the burden of the meaningful use program requirements.

- **Sharing Health Information (Interoperability).** Hospitals collectively have invested hundreds of billions of dollars implementing EHRs and other health information technology (IT) tools that do not easily share data to support care, engage patients or provide the data and analytics to support new models of care. Failing to resolve the interoperability challenges will lead to excess spending on inefficient work-arounds, inadequate data to support new models of care and continued accusations of “information blocking.”

AHA is advocating for more consistent use of standards, better testing of health IT and more transparency about vendor products, while educating policymakers on how hospitals share information. We are working with a range of private sector partners to identify the best approach to advance interoperability through private-sector leadership. These ideas will be shared with the new Health IT Advisory Committee and federal government as it implements the interoperability provisions of the 21st Century Cures Act.

- **Protecting Health Information (Cybersecurity).** The Cybersecurity Information Sharing Act of 2015 established mechanisms and liability protections for sharing threat information among and between the public and private sectors. It also requires the HHS Secretary to report on and create a task force to improve cybersecurity in the health care field. These are welcome developments, as the health care field is experiencing escalating attacks on its information systems by bad actors seeking to disrupt connected systems and access private information. At the same time, the HHS Office for Civil Rights regulates how health care entities secure their systems, requires notification of breaches, and can assess fines on health care providers.

AHA will work with the federal government to identify and disseminate best practices for protecting critical infrastructure from cyberattack and increasing information sharing. AHA also will continue in its role in educating health care leaders on the importance of cybersecurity. We urge greater national protections against cyber criminals and a regulatory approach that recognizes that cyberattacks are criminal acts.

- **Administrative Simplification.** By law, health care providers, health plans and clearing houses use specific transaction standards in the course of billing and paying for health care services (HIPAA transactions). HHS is likely to introduce

new versions of these standards in 2017. What is not clear is whether the transition to a newer version of the standards will be required for all of the existing transactions or whether HHS will introduce each transaction standard separately and under a different timeline. HHS also is likely to introduce a new transaction, the attachment standard to the mix of existing standards. Additionally, HHS will begin introduction of a new Medicare health insurance card number for beneficiaries to replace the existing number based on the beneficiary's Social Security Number.

AHA will safeguard against excessive burden in reporting requirements, and will continue to inform members about changes in HIPAA standards; evaluate whether the return on investment to a newer version is worthy of adoption; and if so, help prepare for a successful transition.

- **Health Plan Consolidation.** Early this year, the U.S. District Court for the District of Columbia blocked the proposed acquisitions involving four of the five major U.S. health insurance companies (Aetna's proposed acquisition of Humana and Anthem's proposed acquisition of Cigna). The judge in the Aetna/Humana case determined that the proposed merger was likely to substantially lessen competition for individual MA plans in all 364 counties challenged by the federal government. In addition, a different District Court judge rejected Anthem's prime defense that any anticompetitive effects of the proposed acquisition of Cigna would be outweighed by efficiencies gained as a result of further reducing payments to providers. As a result of its court loss, Aetna announced in February that it would not appeal and agreed to pay Humana \$1 billion as a condition of the failed deal. Anthem recently lost its appeal of the District Court's decision blocking the deal, and its merger partner, Cigna, has sued in state court to terminate the merger agreement.

AHA vigorously supported the Department of Justice's (DOJ) challenge of both deals, providing input to federal officials about the negative impacts that would result from these acquisitions. In March of this year, AHA continued its efforts by filing a friend-of-the-court brief in the Anthem appeal, urging the U.S. Court of Appeals for the District of Columbia Circuit to affirm the lower court's decision to block Anthem's proposed acquisition of Cigna. As AHA urged, the court recognized what antitrust analysis of health insurance mega-mergers found: Product variety, quality, innovation, and efficient market allocation – all increased through competition – are equally protected forms of consumer welfare. We are pleased that this ruling has prevented the deal from moving forward while we continue to work with others to foster innovation in the health care field and protect health care affordability for all Americans.

- **Hospital Realignment.** Hospitals are reshaping the health care landscape by striving to become even more integrated, aligned, efficient and accessible to the community. To support these changes, it is important to standardize the merger review process between the two federal antitrust agencies. The Federal Trade

Commission (FTC) frequently has used its own internal administrative process to challenge a hospital transaction, an option not available to DOJ, which increases the time and expense of defending a transaction and the likelihood of an outcome that favors the agency.

AHA urges Congress to pass of the Standard Merger and Acquisition Reviews Through Equal Rules (SMARTER) Act (H.R. 659), which would help rebalance the merger review process. We also urge quick reintroduction and passage of an identical bill in the Senate.

- **Barriers to Care Transformation.** Hospitals are adapting to the changing health care landscape and new value-based models of care by eliminating silos and replacing them with a continuum of care to improve the quality of care delivered, the health of their communities and overall affordability. Standing in the way of their success is an outdated regulatory system predicated on enforcing laws no longer compatible with the new realities of health care delivery. Chief among these outdated barriers are portions of the Anti-kickback Statute, the Ethics in Patient Referral Act (also known as the “Stark Law”) and certain civil monetary penalties.

AHA urges Congress to create a safe harbor under the Anti-kickback Statute to protect clinical integration arrangements so that physicians and hospitals can collaborate to improve care, and eliminate compensation from the Stark Law to return its focus to governing ownership arrangements.

- **Accreditation Standards and Medicare Conditions of Participation.** Well-designed quality standards and accreditation surveys help health care delivery systems provide safe, effective care. However, regulations often lack clarity or conflict with the requirements of other standards-setting organizations, and they can become outdated as the science of care improves. Many of the standards used by Medicare and accrediting bodies were developed with a siloed approach to care delivery that is no longer aligned with practice in the field.

AHA is working with the Administration and accreditation bodies to modify standards so that they support integrated and coordinated care, and to ensure that regulations are clear, well-vetted and consistent.



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