

2018

# ADVOCACY AGENDA



American Hospital  
Association®

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# 2018 Advocacy Agenda

**A**merica's hospitals and health systems are shaping our future to fulfill our vision of a society of healthy communities where all individuals reach their highest potential for health. To reach that vision, the AHA and our members are committed to:

- » ***Coverage and access for all;***
- » ***High-value care;***
- » ***Patients, families and other stakeholders being involved as partners;***
- » ***Well-being and prevention; and***
- » ***Providing services in a coordinated, seamless manner.***

For 2018, we have developed a forward-thinking advocacy agenda to positively influence the environment for patients, communities and the health care field. We will work hand in hand with our members; the state, regional and metropolitan hospital associations; national health care organizations; and other stakeholders to develop and implement an advocacy strategy to fulfill our vision.



*Advancing Health in America*

## SUSTAIN HEALTH COVERAGE

- **Preserve the Gains in Health Coverage by Advancing Alternatives to the Federal Individual Mandate.** As part of the 2017 Tax Cuts and Jobs Act, Congress repealed, effective in 2019, the requirement to have health coverage. This “individual mandate” was included as part of the Affordable Care Act (ACA) and was intended to help make coverage affordable. In crafting the ACA, Congress recognized that some provisions intended to protect consumers, such as the disallowance of medical underwriting and requirements for a minimum benefit package, could increase the cost of coverage. The individual mandate, along with premium and cost-sharing subsidies and the employer mandate to offer coverage, was intended to increase enrollment to ensure a healthy risk pool and lead to more affordable coverage. The Congressional Budget Office (CBO) estimates that the repeal of the individual mandate will reduce the number of individuals with health coverage by 13 million by 2027 across nearly every coverage sector: employer-sponsored, Medicaid, and the individual market.

***The AHA will work with Congress and other policymakers to promote alternatives to the individual mandate. Alternatives under evaluation include state-level coverage mandates and increasing the number of individuals eligible for subsidies, among other ideas.***

- **Enhance Marketplace Stability.** More than 10 million Americans rely on the Health Insurance Marketplaces for health coverage. While all marketplaces will have at least one insurer selling plans in 2018, some markets are not yet stable, as there is volatility in insurer participation and double-digit premium increases in some markets. A number of factors have contributed to this instability. In some cases, demographic factors, such as a small population base and disproportionately unhealthy population, can make a market unattractive to insurers and expensive for consumers. The federal and state regulatory structure also plays a critical role.

***The AHA urges Congress and the Administration to take steps to stabilize the marketplaces, including fully funding the cost-sharing reductions, implementing a reinsurance program, ensuring accurate risk adjustment for plans, increasing federal outreach and enrollment efforts, and protecting against plans that do not offer sufficient consumer protections, including access to a comprehensive set of services.***



■ **Support State-level Innovation to Sustain and Improve Coverage and Access.**

States have significant flexibility to modify their Medicaid programs through section 1115 waivers and may use section 1332 waivers to stabilize insurance markets and provide alternative coverage options. The Administration has signaled its intent to leverage waiver authority to allow major changes in these programs and has released new guidance related to 1115 waivers that create both opportunities and risks for hospitals and health systems, including waivers that would permit states to implement work or “community engagement” requirements, waive retroactive coverage and presumptive eligibility, as well as the ability of states to condition eligibility and drug testing. In addition, some in Congress are considering modifications to the 1332 waiver authority, including removing the requirement that state legislatures pass authorizing state legislation, extending the duration of waiver approval, streamlining the federal approval process, and loosening requirements regarding comprehensiveness of coverage and consumer affordability.

***The AHA supports the ability of states to use waivers to develop innovative approaches to improve coverage and access to care for their populations. However, we continue to advocate for safeguards that ensure continued access to affordable coverage for beneficiaries and adequate payment for the providers that serve them. A reformed, streamlined Medicaid waiver process must preserve stakeholders’ ability to contribute meaningful input through a robust engagement process.***

- **Ensure Sustainability of the Medicaid Program.** The Medicaid program provides coverage to approximately 75 million Americans and is the primary source of coverage for low-income individuals, including children, the elderly, and the disabled. The program is jointly financed by the federal and state governments, which spent approximately \$575 billion in total on the program in 2016. Both Medicaid enrollment and spending have grown since the ACA expanded program eligibility at state option to low-income, childless adults. This growth was one driver behind recent efforts by federal policymakers to restructure Medicaid financing and eligibility as part of ACA “repeal and replace” legislation, and future reforms to the program are expected.

***The AHA continues to advocate for both short- and long-term solutions to Medicaid sustainability. These include:***

- ***Expanding value-based contracts with providers and managed care plans;***

- ***Investing in data infrastructure and technology-enabled care coordination tools;***
  - ***Developing new care and payment models to better manage high-need individuals, including addressing the underlying causes of poor health by investing in and coordinating with social services; and***
  - ***Facilitating states' ability to innovate through waivers with appropriate safeguards in place. In addition, the AHA will continue to identify other solutions that address significant cost-drivers on the program, including the financing of long-term care.***
- **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, but Congress passed a six-month extension. 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.

***The AHA urges Congress and the Administration to work with hospitals and health systems 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. The AHA will work with the government as it develops 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.***

## PROTECT PATIENT ACCESS TO CARE

- **Protect the 340B Drug Pricing Program.** The 340B Drug Pricing Program enables hospitals that serve many low-income and uninsured patients to purchase prescription drugs at a discount from drug manufacturers and use the savings to provide a range of comprehensive health services to their local communities. This program has played an important role in helping hospitals stretch already scarce federal resources to expand access to care, enhance community outreach programs and offer unique health services like free vaccines, clinical pharmacy benefits and smoking cessation classes. However, without further action, the Centers for Medicare & Medicaid Services (CMS) will reduce Medicare payments by nearly 30 percent for drugs purchased through the 340B program for many hospitals – even though there is no cost to the federal government. Cuts this severe would dramatically threaten access to care for many patients in communities across the country. At the same time, some members of Congress have proposed new reporting requirements for participating hospitals that would add a significant layer of administrative burden without increasing the value of the program.

***We urge Congress to pass H.R. 4392, which would prevent the significant cuts to Medicare reimbursement for some 340B hospitals from taking effect, and to reject any proposals that add wasteful administrative burden to the program and the 340B covered entities without providing any value to patients. In addition, we will continue to pursue legal redress from CMS's proposal.***

- **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.

***The AHA urges Congress to reject misguided proposals to change the CAH program.***

- **Tax-exempt Status.** Based on data tax-exempt hospitals report to the Internal Revenue Service on their annual returns, the country's investment in tax exemption for hospitals has produced an excellent return. Most recently, Ernst & Young analyzed data from the 2013 tax year for 1,300 hospitals from around the country. The data showed that the value of total benefits to the community was 11 times the value of the tax exemptions hospitals received. Community benefit

expenditures averaged 11.7 percent of the hospitals' total expenses. 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.

***The AHA will continue to collect and report the most current information on the community benefit hospitals provide. While tax-exempt status was not adversely affected in the final tax reform legislation passed last year, the AHA will remain vigilant. This information will be essential to demonstrate the positive return communities receive from hospital tax exemption as Congress continues its review of the tax code. In addition, we will work with state hospital associations to combat efforts to limit tax benefits available to non-profit hospitals.***

- **Capital Financing.** One of the many ways the federal government invests in human capital and innovation in the United States is by granting access to low-cost, tax-exempt financing to hospitals whose health, public service, education, and research missions provide a wide range of societal benefits. Basic to community infrastructure, hospitals are economic mainstays, providing stability and job growth. Access to tax-exempt private activity bonds (PABs) enables hospitals to lower their financing costs by 1 to 2 percentage points and often enables needed projects that are not otherwise financially feasible, particularly in rural areas.

***The AHA urges Congress to preserve the tax exemption for 501(c)(3) hospital PABs. To help further reduce costs, particularly for smaller hospitals, outdated limits on bank purchase of tax-exempt bonds should be changed to account for inflation. Since bank-qualified bonds were first introduced in 1986, local authorities have been limited to issuing a maximum of \$10 million in bank-qualified bonds every year. The AHA supports S. 1925, introduced by Sens. Menendez and Cardin, to increase the annual limit to \$30 million.***

Additionally, the Tax Cuts and Jobs Act's change in the way companies could deduct interest expense on their debt is disadvantageous for companies carrying a significant debt load. Investor-owned hospitals have made significant investments in the communities they serve – particularly rural areas – in recent years. These investments, made through borrowing, were aimed at increasing access to care, and often times reviving distressed community hospitals. The bill also set caps on nonprofit executive compensation.



***The AHA urges Congress to make permanent the new tax law's definition of taxable income for these hospitals as proposed in the House-passed bill and will pursue changes to mitigate the impact of the caps on executive compensation.***

- **Site-neutral Payments.** Section 603 of the Bipartisan Budget Act of 2015 (BiBA) enacted site-neutral payments for services furnished in new, off-campus provider-based hospital outpatient departments (HOPDs) (other than emergency department services). Subsequently, with the AHA's support, the 21st Century Cures Act established exceptions for certain off-campus HOPDs that were under construction at the time of BiBA. For calendar year (CY) 2018, Medicare pays for services furnished in new off-campus HOPDs at only 40 percent of the usual outpatient prospective payment system (OPPS) rate. Some policymakers, including the Medicare Payment Advisory Commission (MedPAC), have advocated for even greater use of such "site-neutral" payments.

***The 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 2019 and beyond in the most favorable and flexible manner possible.***

- **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 (IME) 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 IME adjustment. Members of Congress 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.

***The AHA urges Congress to reject reductions in Medicare funding for IME and direct GME. Additionally, we urge Congress to pass the Resident Physician Shortage Reduction Act to increase the number of Medicare-funded residency positions. We also urge appropriate funding of training programs for nurses and***

***other allied professionals and actions to expand scope of practice laws and allow non-physicians to practice at the top of their license.***

- **Children's Hospitals Graduate Medical Education.** The Children's Hospitals Graduate Medical Education (CHGME) program was created by Congress in 1999 to support graduate medical education programs at children's hospitals that train resident physicians. The program was reauthorized most recently in 2013 and must be reauthorized this year.

The purpose of the program is to provide 58 independent children's hospitals in more than 30 states with funds to train pediatricians and pediatric specialists. Freestanding children's hospitals typically treat very few Medicare patients and, therefore, do not receive Medicare funding to support medical training of residents; the CHGME program helps fill this gap. CHGME is the major source of funding for training of pediatricians, pediatric specialists and pediatric researchers. In addition to training the next generation of pediatricians and pediatric sub-specialists, these hospitals care for many vulnerable children. Currently, independent children's hospitals train over 45 percent of all general pediatricians, 57 percent of pediatric specialists, and the majority of pediatric researchers. Unlike Medicare's Graduate Medical Education program, CHGME is funded through annual appropriations. The program has enjoyed broad congressional support since its inception and is currently (FY 2018) funded at \$315 million.

***The AHA supports the Children's Hospital GME Support Reauthorization Act of 2018 (S. 2597/H.R. 5385) to reauthorize the CHGME program for an additional five years and fund it annually at \$330 million.***

- **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.

***The AHA urges Congress to refrain from further cuts to Medicare bad debt.***

- **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 physician-owned hospitals. The Patient Access to Higher Quality Health Care Act of 2017 (H.R. 1156/S. 1133) 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 more cherry-picking of healthier, better-insured patients and jeopardize access to critical services in many communities.

***The 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.***

- **Rein in Escalating Drug Prices.** Spending on pharmaceuticals has increased dramatically over the past several years. The burden of this increase falls on all purchasers, including patients and the providers who treat them. For example, hospitals frequently see patients show up in the emergency department or return for follow up care sicker than when they left because they were unable to afford their medications. Just as many patients face difficult choices when considering purchasing medications, hospitals, as drug purchasers, face significant resource constraints and trade-offs as spending on drugs increases. The primary driver behind increased drug spending is higher prices, not increases in utilization. Within the health care field, "pharmaceuticals" was "the fastest growing category" in terms of pricing for every month of 2016 and for most months of 2017. We see both higher launch prices for new drugs and increases in prices for existing drugs. Limited competition and drug shortages have facilitated this price growth.

***The AHA urges Congress and the Administration to support patients and providers by taking immediate action to rein in the rising cost of drugs, including by taking steps to increase competition among drug manufacturers, improve transparency in drug pricing, advance value-based payment models for drugs, and increase access to drug therapies and supplies. We continue to advocate for passage of the Creating and Restoring Equal Access to Equivalent Samples Act (CREATES Act).***

- **Protect State Funding for Medicaid Through 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.

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

- **Post-acute Care (PAC) Payments.** The PAC field continues to undergo a major transformation. In FY 2018, all long-term care hospitals (LTCHs) will have transitioned to the new, two-tiered payment system, under which one out of two cases is paid a far lower "site-neutral" rate that is comparable to an inpatient prospective payment system (PPS) rate. Also underway are CMS's regulatory efforts to reform the skilled nursing facility and home health PPSs, with refined proposals for payment models expected for 2019. Further, MedPAC continues to urge Congress to accelerate the implementation of the statutorily-mandated PPS that jointly applies to all four PAC settings. The magnitude of these changes means that these providers and their patients are facing an overwhelming amount of change and volatility.

***Given the scope of the changes already underway for post-acute care, the AHA urges Congress to reject any new changes or payment cuts that would reduce payment accuracy or increase administrative burden for these services, as any such changes would threaten access to medically necessary care. Instead, we encourage the facilitation of changes that will preserve access to medically necessary care, improve payment accuracy, and streamline excessive regulatory demands.***

- **Underpayment of LTCH Site-neutral Cases.** The implementation of site-neutral payment for certain LTCH cases, as mandated by the Improving Medicare Post-Acute Care Transformation Act (IMPACT) of 2014, is causing a major upheaval in the field. Site-neutral cases are paid an inpatient PPS-comparable rate; however, AHA analyses indicate that they have an acuity and cost profile that more closely resembles that of traditional LTCH cases, which are paid a far higher standard LTCH PPS payment. AHA analyses also indicate that payments fall substantially short of the cost of care for these site-neutral cases, covering only 47 percent of costs under full implementation of the new payment system.

***The AHA urges Congress to forgo any cuts that will result in LTCH site-neutral payments falling even further below the cost of providing care, which will jeopardize access for these medically-complex patients.***

- **Modernize and Enhance Medicare Advantage.** The Medicare Advantage (MA) program is an important source of coverage for approximately a third of Medicare beneficiaries. Approximately 50 AHA members sponsor MA plans, and nearly all AHA members contract with such plans to provide services to enrolled Medicare beneficiaries. The MA program is a success when measured on metrics such as marketplace competition, consumer satisfaction and quality of care. However, there are a number of areas where the program can be improved as part of continuous efforts to advance health care quality, health outcomes and health system efficiency, particularly through better integration and coordination of care.

***The AHA successfully advocated for recent changes that would make permanent the MA special needs program, increase plans' ability to tailor benefit packages for certain enrollees, expand plans' ability to use telemedicine, and to incorporate value-based insurance design. The AHA will work with the Administration to implement these new provisions, as well as continue to advocate for appropriate funding for and oversight of the MA program.***



## ADVANCE HEALTH SYSTEM TRANSFORMATION

- **Protect Against Health Plan Consolidation.** Last year, the courts 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 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. As the AHA urged, the court recognized what our analysis of health insurance mega-mergers found: none of the claimed benefits of this massive consolidation outweighed the likely harm to competition or consumers, particularly to the efforts of the hospital field to move forward with innovative ways in which to improve care.

***The AHA will continue to protect consumers against health plan consolidation and work with others to foster innovation in the health care field and protect health care affordability for all Americans.***

- **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 center
  - Urgent care center
  - Virtual care strategies
  - Frontier health system
  - 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, the AHA is advocating that policymakers make the specific legislative and regulatory changes***

***that are necessary to enable their implementation. Such changes should be a priority so that hospitals and health systems can better ensure access to care in vulnerable urban and rural communities.***

- **Support 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.

***The AHA urges Congress to pass 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 reintroduction and passage of an identical bill in the Senate.***

- **Remove 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 (CMPs).

***The 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.***

- **Complete the Broadband Infrastructure.** According to the Federal Communications Commission (FCC), 34 million Americans still lack access to adequate broadband. Lack of affordable, adequate broadband infrastructure impedes routine health

care operations, such as widespread use of electronic health records (EHRs) and imaging tools, and limits the ability to use telehealth in both rural and urban areas. The AHA is pleased that the FY 2018 omnibus appropriations bill included measures to expand the broadband infrastructure, including \$600 million to the Department of Agriculture for a new pilot program offering grants and loans for broadband projects in rural areas with insufficient broadband.

***The AHA is also advocating for substantially increased funding for the FCC's Rural Health Care Program, which supports broadband adoption for non-profit rural health care providers. The program also needs improvements to reduce administrative challenges and provide a sufficient level of subsidy for remote health care providers.***

- **Expand Telehealth.** As the use of telehealth has grown in recent years, well over half of U.S. hospitals connect with patients and consulting practitioners at a distance through the use of video and other technology. However, there are several barriers to wide use of telehealth, including statutory restrictions on how Medicare covers and pays for telehealth. While the AHA was pleased that the Bipartisan Budget Act (BiBA) of 2018 expanded Medicare coverage for telestroke and provided waivers in some alternative payment models, more fundamental change is needed. In addition, many hospitals and health systems find that the infrastructure costs for telehealth are significant. Establishing telehealth capacity requires expensive videoconferencing equipment, adequate and reliable connectivity to other providers and staff training, among other things. The FY 2018 omnibus appropriations bill included more than \$50 million for rural telehealth programs, but greater support is needed.

***The AHA urges Congress to further expand telehealth capacity by establishing a grant program to fund telehealth start-up costs. Congress also should remove Medicare's limitations on telehealth by: (1) eliminating geographic and setting requirements so patients outside of rural areas can benefit from telehealth; (2) expanding the types of technology that can be used, including remote monitoring; and (3) covering all services that are safe to provide, rather than a small list of approved services.***

- **Share Health Information (Interoperability).** Hospitals collectively have invested hundreds of billions of dollars implementing EHRs and other health 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.”

***The AHA supports 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 will work with the new Health IT Advisory Committee and federal government to promote private-sector leadership and flexible approaches to the implementation of the interoperability provisions of the 21st Century Cures Act, including the creation of a Trusted Exchange Framework and Common Agreement.***

- **Protect Health Information (Cybersecurity).** The health care field continues to experience escalating attacks on its information systems by bad actors seeking to disrupt connected systems and access private information. At the same time, the Office for Civil Rights within the Department of Health and Human Services (HHS) regulates how health care entities secure their systems, requires notification of breaches, and can assess fines on health care providers. As required by the Cybersecurity Information Sharing Act of 2015, the government has established mechanisms and liability protections for sharing threat information among and between the public and private sectors, released a task force to improve cybersecurity in the health care field, and begun developing best practice guidance for providers. More, however, needs to be done.

***The AHA will continue to work with the federal government to identify and disseminate best practices for protecting critical infrastructure from cyberattack and increase information sharing. The AHA also will continue in its role in educating health care leaders on the importance of cybersecurity. The AHA will advocate for greater national protections against cyber criminals, federal programs to address the shortage of trained cybersecurity professionals, greater Food and Drug Administration (FDA) oversight of the security of medical devices, a regulatory approach that recognizes that cyber attacks are criminal acts, and changes to the fraud and abuse rules to allow hospitals to share security resources with community physicians, if they choose to.***

- **Hospital “Right-sizing.”** As the hospital field engages in its most significant transformation to date, many are fighting to survive — potentially leaving communities at risk for losing access to health care services. This could be

devastating to the individuals living in these communities, and the concern for them is only growing as significant pressures on the health care sector continue. As such, the AHA's report on Ensuring Access to Care in Vulnerable Communities identified several ways to preserve access to essential health services in vulnerable communities. Several of these strategies involve transformations to the actual physical plant. For example, the inpatient-outpatient transformation, emergency medical center and urgent care center strategies would typically require facility renovations or improvements to restructure how and where the hospital offers its services.

***The AHA urges Congress to help ensure that vulnerable communities are able to maintain access to essential health care services by providing infrastructure funding for facilities that restructure their facilities and services offered to match community needs.***

- **Making Care More Affordable Through Comparative Effective Research.** In order to improve the affordability of health care in America, the AHA supports the development and use of evidence-based medicine. Comparative effectiveness research (CER) evaluates the impact of different medical options for treating a given medical condition for a particular set of patients. Moreover, when CER includes the costs of new innovations, it can be used to assess the value of every dollar spent. While medical technology accounts for a large percent of the growth in per capita health spending, medical decision makers may not know whether a particular technology is effective relative to other treatments. Patients, providers, employers and insurers should have the most accurate information so they can make the best health care decisions. Additionally, CER is a key mechanism for improving quality, decreasing unjustified variation in care and reducing health care costs.

***The AHA will work with Congress and the Administration to further advance CER.***



## ENHANCE QUALITY AND PATIENT SAFETY

- **Building Capacity for Emergency Preparedness and Response.** When a disaster strikes, people turn to hospitals for help. Congress recognized that role in the Pandemic and All Hazards Preparedness Act (PAHPA) by creating the Hospital Preparedness Program (HPP), the primary federal funding mechanism for emergency preparedness. Since 2002, the HPP has provided critical funding and other resources to aid hospitals' response to a wide range of emergencies. The HPP has supported greatly enhanced planning and response; facilitated the integration of public and private sector emergency planning to increase the preparedness, response and surge capacity of hospitals; and improved state and local infrastructures that help health systems and hospitals prepare for public health emergencies. These investments have contributed to saving lives during many events, from the Boston Marathon bombing to the Ebola crisis and recent hurricanes in Texas, Florida and Puerto Rico. However, funding for the HPP has not kept pace with the ever-changing and growing threats faced by hospitals, health care systems and their communities. Indeed, authorized funding levels and annual appropriations for the HPP have significantly declined since the program began.

***The AHA believes the HPP should be authorized at a sufficient level. As such, we urge Congress to incorporate within PAHPA reauthorization (which must occur before Oct. 1, 2018), the Hospital Preparedness Program Reauthorization Act of 2018 (H.R. 4776), which would increase the HPP's authorization level to \$515 million for each fiscal year through FY 2023, doubling its current level of appropriated funding. This investment will help prepare and equip our health care system nationwide in advance of future disasters and public health emergencies.***

***In addition, we support incorporating competition and innovation into the awarding of HPP funds by allowing entities such as academic medical centers and hospital associations to compete, alongside state and local health departments, to be eligible awardees overseeing the program in their jurisdictions. We also support efforts to improve the efficiency of the HPP by capping the amount of the HPP funds that awardees can use for direct overhead at 15 percent.***

- **Drug Shortages.** Drug shortages are an ongoing major public health concern facing hospitals and clinicians. The type of drugs most often in short supply are generic sterile injectable products, which typically have only a few suppliers and are prone to shortages due to quality problems during the manufacturing process. Shortages leave clinicians scrambling to get a supply of the drug, compounding in

cases where it is possible, or recommending an alternative therapy if one exists. Legislation enacted in 2012 requires drug manufacturers to notify the FDA of any interruption in production that is reasonably likely to lead to reduction in supply of a drug in the U.S. – but not the reason for the interruption or the expected timeline for resolution. The impact of Hurricane Maria on the island of Puerto Rico, which houses significant drug manufacturing infrastructure, exacerbated drug shortages, especially shortages of small volume intravenous (IV) solutions and pediatric formulations of amino acids.

***In order to help prevent and mitigate future shortages of drugs, the AHA urges Congress to:***

- ***Require drug manufacturers to disclose the problem causing the supply interruption and an expected timeline to resolve it;***
  - ***Require drug manufacturers to establish contingency plans and/or production redundancies for supply interruptions, especially when there are three or fewer manufacturers producing a drug;***
  - ***Improve transparency by requiring that manufacturers disclose to FDA the location of production, including whether a contract manufacturer is used;***
  - ***Instruct FDA to explore incentives to encourage additional manufacturers to begin producing drugs that are chronically in shortage;***
  - ***Examine drug shortages as a national security initiative by requiring that HHS and DHS identify ways to support manufacturers and the health care provider community in preparing for an mitigating future disasters and possible supply disruptions; and***
  - ***Request that the FTC consider the potential risk for drug shortages when reviewing drug company mergers and acquisitions.***
- **Behavioral Health.** The AHA is concerned about persistent gaps in access to behavioral health services; the shortage of mental health professionals in many communities; and the need to truly establish parity for mental health care. Of paramount importance to address behavioral health need is the preservation of health insurance coverage, including Medicaid.

***The 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, the AHA supports removing barriers to mental health treatment, such as amending the Medicaid Institutions for Mental Disease (IMD) exclusion, eliminating the Medicare 190-day lifetime limit on inpatient psychiatric treatment, and continuing to provide additional support for enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA). Finally, to protect patients from unintended errors, the AHA urges Congress to amend 42CFR, Part 2 to allow behavioral health information to be protected by HIPAA in the same way that other private and potentially sensitive health information is protected from disclosure. The current rule prohibits emergency room clinicians and other physicians treating patients for physical ailments from having access to critical information about the patient's behavioral health conditions and treatments unless separate consent is obtained.***

- **Opioid Crisis.** Similar to the gaps in access to behavioral health care, the AHA emphasizes the urgent need to address opioid addiction and its repercussions. Already this year, HHS has declined to make it easier to share patients' substance abuse treatment records among providers working in accountable care organizations, which can cripple overall care. Without swift and large-scale efforts, the opioid crisis will continue to grow.

***The AHA encourages Congress to enhance access to Medication-Assisted Treatment and continue to provide additional support for enforcement of the MHPAEA. Additionally, the AHA supports strengthening prescription drug monitoring programs and prescriber education through medical and dental school training.***

- **Advanced Illness Management.** The health care landscape is being reshaped to support improved coordination across the care continuum, and this must extend to 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. The BiBA requires the Government Accountability Office to submit a report to Congress on the establishment of a Medicare Part B payment code for a visit for longitudinal comprehensive care planning services. 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.

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

- **Medicare Physician Payment.** The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 created a two-track physician quality payment program (QPP) that ties a portion of physician payment to quality and cost, and includes incentives for participation in advanced alternative payment models (APMs) that lead to more integrated, better coordinated care. As urged by the AHA, CMS adopted a gradual, flexible increase in QPP requirements, and reduced burden by allowing hospital-based clinicians to use their hospital's Medicare value-based purchasing results in the Merit-based Incentive Payment Systems (MIPS). Yet, opportunities remain to improve CMS's implementation of MIPS and to expand opportunities to participate in APMs.

***The AHA continues to urge CMS to implement the QPP in a flexible manner that minimizes unnecessary burden on clinicians. We also will urge CMS to expand MIPS facility-based measurement to include other provider types (such as inpatient rehabilitation facilities (IRF)), and to improve the MIPS cost measures. Successful MACRA implementation also will include creating additional voluntary advanced APMs that reward clinicians who partner with hospitals to reduce cost and improve quality.***

- **Health Disparities.** Research has shown that individuals of color, of various ethnic backgrounds, religions, sexual preferences, 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, personal habits and life choices, the health care received and different community and environmental factors. The AHA and its members strive to help all individuals achieve their highest potential for health. In particular, the AHA is focusing on ensuring that everyone in the United States has access

to all of the care they need when they need it, and that it is safely and efficiently delivered. We are collaborating with other key stakeholders in communities across the nation to better understand the important factors affecting the health of individuals in each community and promote better health, with a special concentration on reducing disparities in health outcomes.

***The AHA supports the hospital and health system field in 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 in 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. The AHA and its member organizations have achieved important and meaningful improvements through rigorous adoption of evidence-based practices that have been shown to prevent errors. Our members have successfully reduced infections, prevented falls, improved decision support, and worked to improve the teamwork and safety culture in hospitals, but we have not yet eliminated all preventable harm. Additionally, some types of errors remain under studied, so we lack understanding of the underlying causes of those errors and successful strategies for preventing them. One clear example of an area that needs significant study is diagnostic error, as the National Academy of Medicine has indicated in its 2015 report, *Improving Diagnosis in Healthcare*. Further, we recognize that the adoption of new technologies, procedures and drugs can advance outcomes for patients, but also may result in additional safety risks.

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

- **Sociodemographic Adjustment.** A body of research demonstrates that performance on a variety of outcome measures used in CMS quality reporting and pay-for-performance programs – including readmissions, mortality efficiency and patient experience – can be influenced by sociodemographic factors beyond providers' control such as being dually eligible for Medicare and Medicaid, and income. As urged by the AHA, Congress and CMS have taken important first steps to incorporating sociodemographic adjustment in programs where necessary and



appropriate. For example, the 21st Century Cures Act requires CMS to implement sociodemographic adjustment in the hospital readmissions penalty program starting in FY 2019. And, the physician MIPS program includes a “complex patient bonus” that recognizes practices caring for large numbers of dual-eligible patients. However, many measures and programs – such as hospital star ratings and VBP – still lack sociodemographic adjustment, and any adjustment approach will need ongoing refinement.

***The AHA will continue to urge CMS to incorporate social risk factor adjustment into its quality measurement and pay-for-performance programs where necessary and appropriate. We also will urge CMS use the evolving science around the best ways to adjust for social risk factors to update its approach as needed.***

- **Hospital Star Ratings.** Despite objections from the 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 conceptual approach to the star ratings is flawed and there were substantial calculation errors made in the originally published ratings. The AHA encouraged CMS to suspend these star ratings to fix the mathematical errors and to reconsider how to approach star ratings. For most of 2017, CMS suspended the star ratings and worked to correct the mathematical errors. In late December, 2017, CMS republished the star ratings, having corrected most, but not all, of the calculation errors.

***The AHA remains concerned about the validity of the approach CMS has taken to calculating star ratings. The association urges the Administration to suspend the star ratings from the Hospital Compare website and work with industry to develop a more conceptually sound approach to giving patients useful information.***

## PROMOTE REGULATORY RELIEF

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- **Patients Not Paperwork.** A recent AHA report indicates that the regulatory burden faced by hospitals, health systems and post-acute care providers is substantial and unsustainable. Specifically, hospitals, health systems and post-acute care providers spend nearly \$39 billion a year solely on administrative activities related to regulatory compliance. In addition, the analysis found that an average-sized hospital dedicates 59 full-time equivalent employees to regulatory compliance; one-quarter of those employees are physicians, nurses and other health professionals who would otherwise be caring for patients. In addition, an average-sized community hospital spends \$7.6 million annually to comply with this subset of federal regulations – this equates to \$1,200 every time a patient is admitted.

***The AHA urges CMS to reduce the overall administrative burden imposed on hospitals, health systems and post-acute care providers. Doing so will enable providers to focus more on patient care and reinvest resources to improve care, improve health and reduce costs.***

- **Measures that Matter.** Improvements in quality and patient safety are accelerating, but the sheer 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. CMS has proposed a significant first step in this direction with its “Meaningful Measures” framework and proposed reduction in required measures in the 2019 inpatient PPS proposed rule. But there is more work to be done.

***The AHA is working with stakeholders to advance streamlined, prioritized quality reporting requirements so that they focus on “measures that matter” most to improving health and outcomes.***

- **Post-acute Care Quality Measurement.** The IMPACT Act of 2014 required CMS to implement standardized and interoperable quality measures and patient assessment elements across each post-acute care setting’s quality reporting

program. This has resulted in the addition of several new quality measures in the past three years, and there are still many more items to add. Each new item increases the reporting burden on already overtaxed post-acute care providers, without evidence of improved patient outcomes.

***The AHA urges CMS to use a gradual and flexible approach to the implementation of the IMPACT Act requirements.***

- **Electronic Clinical Quality Measures.** Hospitals are required to submit electronic clinical quality measures (eQMs) in the Hospital Inpatient Quality Reporting Program and the EHR Incentive Program but report several challenges to doing so. Moreover, when hospitals compare the same chart-abstracted and eQM measure, they find that the eQM does not yield the same result. CMS recently proposed to continue the eQM reporting requirements, but will remove seven of the 15 eQMs for the CY 2020 reporting period (FY 2022 payment year), stating that the cost of collecting the measures outweighs the benefit of continued use.

***The AHA will continue to advocate that CMS suspend all regulatory requirements that mandate submission of eQMs, improve eQMs so they are specified in a manner that permits accurate data collection from electronic records whenever possible and include eQMs in the meaningful measures work underway at CMS.***

- **EHR Incentive Program.** America's hospitals are strongly committed to the adoption of EHRs, and the transition to an EHR-enabled health system is well underway. We are pleased that CMS proposed some significant changes to the newly renamed Promoting Interoperability program to increase flexibility in 2019. This includes moving to a performance-based scoring system and removing several measures that unfairly hold hospitals accountable for the actions of others. In addition, the agency proposes a 90-day reporting period in 2019 and 2020. Unfortunately, CMS proposes to require the use of the 2015 Edition certified EHR in 2019 and to retain the requirement to connect "apps" to a hospital's system without the ability to vet them for security.

***The AHA will work with members to evaluate the proposed rule and identify recommendations that ensure feasibility of the requirements and allow hospitals to keep their systems secure.***

- **Accreditation Standards and Medicare Conditions of Participation.** Well-designed quality standards help health care delivery systems provide safe, effective care. However, poorly designed standards, standards that are unclear, and poorly executed surveys can create burden without advancing safety and quality. As our study of regulatory burden showed, compliance with the Medicare conditions of participation requires a substantial investment by hospitals. Hospitals strive to be fully compliant with all of the requirements all of the time, but that effort is made more difficult and burdensome if the requirements lack clarity or conflict with the requirements of other standards-setting organizations. Even standards that once seemed right can become outdated as the science of care advances. As hospitals and health systems adapt to changes in science and care delivery, and strive to coordinate care for patients, it is becoming increasingly clear that many standards may not be needed or may need substantial modification. Further, the siloed approach to regulating hospitals and other care delivery organizations as if they were separate and distinct from the other providers caring for those patients may no longer lead to the best outcomes for patients.

***The AHA urges accreditation bodies to streamline and modify standards so that they support integrated and coordinated care, and to ensure that regulations are clear, well-vetted, and consistently enforced.***

- **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 that could harm access to care in rural and underserved communities. For CYs 2010-2013, in response to hospital concerns, the agency prohibited its contractors from enforcing the direct supervision policy in CAHs and small rural hospitals with fewer than 100 beds. Congress has since extended this enforcement moratorium through 2017. In the CY 2018 outpatient PPS final rule, CMS reinstated the enforcement moratorium for CYs 2018 and 2019 in order to give these hospitals more time to comply with the supervision requirements. While we appreciate this additional enforcement discretion, simply allowing more time to comply will not help these vulnerable hospitals due to ongoing physician shortages in these communities.

***The AHA urges Congress to pass the Rural Hospital Regulatory Relief Act of 2017 (S. 243/H.R. 741) to make permanent the enforcement moratorium on CMS’s “direct supervision” policy for outpatient therapeutic services provided in CAHs and small, rural hospitals.***

- **CAH '96-hour' Rule.** CMS previously indicated it would begin enforcing a condition of payment for CAHs that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. While CAHs must maintain an annual average length of stay of 96 hours, they may offer some critical medical services that have standard lengths of stay greater than 96 hours. Enforcing the condition of payment will force CAHs to eliminate these "96-hour-plus" services. However, in the inpatient PPS final rule for FY 2018, CMS indicates its contractors will make reviews of this issue a "low priority." The AHA appreciates CMS's recognition that this condition of payment could stand in the way of promoting essential, and often lifesaving, health care services to rural America. However, while this moratorium offers some comfort, it does not remove the 96-hour certification requirement from the statute, and the AHA remains concerned that CAHs may still be at risk for penalties.

***The AHA will continue to advocate for a legislative solution that permanently removes the 96-hour physician certification requirement as a condition of payment for CAHs and we urge CMS to work with us to support that effort.***

- **Permanently Eliminate Unfair LTCH Regulation.** CMS recently proposed to permanently eliminate the LTCH "25% Rule" beginning in FY 2019 – a change sought by the AHA since the policy was introduced in 2005. With the introduction of LTCH site-neutral payment in 2015 (as mandated by the BiBA of 2013), the need to withdraw the 25% Rule was further heightened, as site-neutral payment is transforming the field by materially reducing overall patient volume and payments.

***Given the absence of a sound rationale for the 25% Rule, which we argued at length for many years, and its negative impact on access to care, plus the magnitude of site-neutral payment, the AHA strongly supports the proposed removal of the 25% Rule – however, we will urge CMS to make a budget-neutral change, rather than the proposed permanent offset, a one-time 0.9 percent cut.***

- **Examine IRF '60% Rule.'** The 60% Rule is designed to focus IRF services on particular types of patients, requiring 60 percent of cases for a prior 12-month period to have one of 13 qualifying conditions ("CMS 13") or a qualifying comorbidity. However, the CMS 13 were implemented in 2004 and may no longer align with current medical practice or the current patient mix that reflects substantial regulatory intervention by CMS, including new admissions criteria



in 2010, and more recently, marketplace changes related to APMs. Some of our members believe that the 60% Rule is out of date and no longer warranted.

***The AHA urges CMS to implement a transparent process to re-evaluate the 60% Rule in recognition of the policy's limitations, most notably its arbitrary access restrictions for patients with diagnoses outside of the CMS 13 qualifying conditions.***

- **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 2018. 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. The Prior Authorization transaction is targeted by the National Committee on Vital Health Statistics as one of the transactions that is in need of process improvement and greater utilization in 2018. A coalition of providers, as well as other health care entities, has been working to improve the business issues that have prevented greater utilization of this standard. 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 starting April 2018 and continuing through April 2019.

***The 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 them prepare for a successful transition. We also will support the field as we transition to a new Medicare beneficiary identifier.***

- **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.

***To make care more affordable, the AHA continues to advocate for comprehensive reforms to the medical liability system, including caps on non-economic damages and allowing courts to limit attorneys’ contingency fees.***

- **RACs.** In recent years CMS has implemented several changes intended to reduce the significant burden hospitals bear as a result of Recovery Audit Contractors (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.

***The 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 incorporate a financial penalty for poor performance by RACs, as measured by Administrative Law Judge appeal overturn rates.***

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