



American Hospital
Association®

2019 Public Policy Agenda

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2019 Advocacy Agenda

In the 2018 mid-term elections, voters made it clear that health care is an important issue to them. And near the top of their list of concerns was the affordability of health care services.

Likewise, government and payers are seeking greater value for their health care dollars. And concerns around the affordability of health care will only grow as overall health care spending continues to rise to meet the needs of an aging America.

The court's December 2018 ruling that the entire Affordable Care Act is unconstitutional only adds to consumers' concerns. Although nothing will change as the case is appealed, the uncertainty about the ACA's fate could cause further instability in the health insurance market.

America's hospitals and health systems understand – and share – consumers' concerns. We will not shy away from this challenge; instead, we have been tackling it head on, taking steps to redesign care and implement operational efficiencies. But we can't do it alone.

Every stakeholder – hospitals, other providers, insurers, drug companies, device makers, the government and patients – has a role to play in this effort.

The American Hospital Association's 2019 public policy advocacy agenda seeks to continue to positively influence the public policy 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.

SUSTAIN THE GAINS IN HEALTH COVERAGE

- Preserve the Gains in Affordable Health Coverage and Further Expand Coverage.** The 2010 passage of the Affordable Care Act (ACA) constituted the largest change to America's health insurance coverage since the creation of Medicare and Medicaid. The law was estimated to expand coverage to 32 million individuals through a combination of public program and private-sector health insurance expansions. Yet several ACA provisions to expand coverage have expired, been changed, delayed or eliminated, or have been declared unconstitutional. Health care coverage is critical to ensuring routine patient access to care, and the AHA promotes the objective of universal coverage. Despite the recent, significant coverage gains, approximately 30 million individuals living in the U.S. are not enrolled in any form of health care coverage, and, for the first time since 2014, the rate of uninsured increased in 2017, and initial evidence suggests the same negative trend for 2018.

The AHA will continue to work with Congress and other policymakers to promote and expand coverage options, such as supporting efforts to expand Medicaid in the remaining non-expansion states by providing those states with the same enhanced federal funding as states that expanded in 2014 and increasing outreach and enrollment efforts to connect people to coverage.

- Ensure the Stability and Affordability of the Health Insurance Marketplaces.** More than 10 million Americans rely on the Health Insurance Marketplaces for health coverage. While all marketplaces had at least one insurer selling plans in 2019, some markets are not yet stable, and premiums and consumer cost-sharing obligations in many markets continue to increase. A number of factors have contributed to this instability, including policy decisions to expand short-term limited duration health plans and other forms of coverage that could significantly reduce enrollment in the Marketplaces.

The AHA urges Congress and the Administration to improve the stability and affordability of the marketplaces, including fully funding the cost-sharing reduction subsidies, implementing a national reinsurance program, conducting robust outreach and enrollment, and protecting consumers from health plans that do not meet all of the consumer protections established in federal law.

- Ensure Patients Can Access All of the Services Necessary to Get and Stay Healthy by Protecting Access to a Minimum Set of Essential Health Benefits.** The ACA established 10 essential health benefits that all individual and small group health plans are required to cover, including maternity care, behavioral health care, emergency services, and hospitalizations, among others. These benefits create the base for comprehensive coverage, and efforts to scale back

these protections leave consumers vulnerable to gaps in coverage when unexpected illness or injury occur.

The AHA urges Congress and the Administration to protect the essential health benefits and limit the sale of plans that are not required to cover these 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 guidance related to 1115 and 1332 waivers that create both opportunities and risks for hospitals and health systems. For example, the updated 1115 guidance would permit states in their Medicaid programs to implement work or “community engagement” requirements, waive retroactive coverage and presumptive eligibility, or condition eligibility on drug testing. New guidance for 1332 waivers relaxes the “guardrails” established in the law that require any waivers to ensure the comprehensiveness and affordability of coverage, among other things.

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 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 over 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 \$577 billion in total on the program in 2017. Both Medicaid enrollment and spending have grown since the ACA expanded program eligibility at state option to low-income, childless adults. This growth is one driver behind efforts by some federal policymakers to restructure Medicaid financing.

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

- ***Encouraging 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.** Last June, President Trump signed into law the VA Maintaining Internal Systems and Strengthening Integrated outside Networks Act of 2018, known as the VA MISSION Act. This bipartisan legislation consolidated the Department of Veterans Affairs' (VA) community care programs into one permanent Veterans Community Care Program and made several other changes to improve the delivery of care for veterans and their families. In February, the VA published a proposed rule that would establish the Community Care Program criteria for determining when covered veterans may receive necessary hospital, medical and extended care 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. One of the predecessors to the forthcoming Veterans Community Care Program was the Veterans Choice Program, which also provided for non-VHA medical care for eligible veterans. The Choice Program was helpful in providing access to health care services for some veterans, but hospitals and health systems consistently found it difficult to obtain timely payment from VA and its contractors.

The AHA urges Congress and the Administration to work with hospitals and health systems as they implement 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 also urges the government to adopt strategies that ensure prompt payment to community providers, thereby supporting veterans' access to community care.

PROTECT PATIENT ACCESS TO CARE

- **Protect the Medicaid DSH Program:** The Medicaid Disproportionate Share Hospital (DSH) program provides essential financial assistance to hospitals that care for our nation's most vulnerable populations – children, the poor, the disabled and the elderly. These hospitals also provide critical community services, such as trauma and burn care, high-risk neonatal care and disaster preparedness resources. Congress cut Medicaid DSH payments in the ACA, reasoning that hospitals would care for fewer uninsured patients as health coverage expanded. However, the projected increase in coverage has not been fully realized due to some states not expanding Medicaid, as well as lower-than-anticipated enrollment in coverage through the Health Insurance Marketplaces.

The Medicaid DSH payment reductions, which the AHA has helped delay, are scheduled to take effect in fiscal year (FY) 2020. The Medicaid and CHIP Payment and Access Commission earlier this year made recommendations to Congress to phase in the cuts, apply unspent DSH funding and change the methodology for how the DSH reductions are allocated to the states.

The AHA urges Congress to again delay the start of the Medicaid DSH cuts given the vital need for the program and urges Congress not to change the method for making the DSH reductions.

- **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. The Centers for Medicare & Medicaid Services (CMS) implemented a drastic cut to Medicare payments for drugs that are acquired under the 340B program as part of the outpatient prospective payment system final rule for calendar year 2018. The AHA, joined by other national hospital associations and hospital plaintiffs, sued the government over the payment cuts. In late 2018, a federal judge ruled in favor of the AHA, saying that the Department of Health and Human Services' (HHS) "adjustment" by nearly 30 percent of 2018 Medicare payment rates for many hospitals in the 340B program was unlawful. While the court issued a ruling agreeing with the AHA and the other plaintiffs that the cuts are unlawful, it has not yet decided on a remedy. The government has indicated it plans to move forward with an appeal following a decision on the remedy in the case.

The AHA continues its advocacy for the 340B program and supports:

- ***Efforts to rescind CMS’s drastic payment cuts for many hospitals in the 340B program and expand drug manufacturer transparency.***
- ***Eliminating the orphan drug exclusion for certain 340B hospitals.***
- ***Expanding the program to reach additional vulnerable communities, including investor-owned hospitals that provide care for underserved populations.***
- ***Program integrity efforts to ensure this vital program remains available to safety-net providers.***

The AHA opposes efforts to scale back, significantly reduce the benefits of or expand the regulatory burden of the 340B program, including proposals to dramatically expand reporting requirements on certain 340B hospitals and impose a moratorium on new entrants into the program. These proposals would involve major changes in hospital inventory practices, could prove to be unworkable in mixed-use settings and are unwarranted given the value the 340B program provides to the communities these hospitals serve.

- **CAH Payment Policies.** Some policymakers are calling for dramatic reductions to the critical access hospital (CAH) program, including the elimination of the 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.** The country’s investment in tax exemption for hospitals has produced an excellent return, based on data tax-exempt hospitals report to the Internal Revenue Service on their annual returns. 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. More recent analysis by AHA of IRS data shows for Tax Year 2015 that the value of total benefits to the community was 13.3 percent of 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 2017 tax reform legislation, 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 oversight of the law. In addition, we will work with state hospital associations to combat efforts to limit tax benefits available to non-profit hospitals.

- **Site-neutral Payments.** Section 603 of the Bipartisan Budget Act of 2015 (BiBA) enacted site-neutral payments for services furnished in newer (referred to as “non-excepted”), off-campus provider-based hospital outpatient departments (PBDs) (other than emergency department services). Subsequently, with the AHA’s support, the 21st Century Cures Act established exceptions for certain off-campus PBDs that were under construction at the time of BiBA. For calendar year (CY) 2019, Medicare continues to pay for services furnished in excepted off-campus PBDs at only 40 percent of the usual outpatient prospective payment system (OPPS) rate. In addition, for CY 2019, citing “unnecessary” increases in the volume of clinic visits in hospital PBDs, CMS finalized, but phased-in over two years, a policy to pay for visits furnished in those off-campus PBDs protected from site-neutral cuts under BiBA (referred to as “excepted”) at the same rate they are paid in non-excepted, off-campus PBDs. Specifically, in CY 2019 excepted off-campus PBDs are paid 70 percent of the OPPS rate for clinic visit services. In CY 2020 and subsequent years, these excepted off-campus PBDs will be paid 40 percent of the OPPS rate for these services. Further, the agency is implementing the clinic visit policy in a non-budget-neutral manner, which means that it is estimated to cut hospital payments under the OPPS by \$380 million in CY 2019. Some policymakers, including the Medicare Payment Advisory Commission (MedPAC), have advocated for even greater use of such “site-neutral” payments.

With the expanded site-neutral policy finalized for CY 2019, CMS has once again shown a lack of understanding about the reality in which hospitals and health systems operate to serve the needs of their communities. CMS has misconstrued Congressional intent with its policy to cut payments for hospital clinic services in excepted off-campus PBDs. Under Section 603, Congress clearly intended to preserve the existing outpatient payment rate for these excepted off-campus PBDs in recognition of the critical role they play in their communities. But CMS’s CY 2019 policy runs counter to this and will instead impede access to care for the most vulnerable patients.

We continue to urge CMS to provide payments that are adequate to cover the costs of providing care so that hospitals and health systems can continue to serve as the access point for community care. In addition, the AHA will continue to urge Congress to reject calls for any additional site-neutral payment policies for hospital outpatient departments.

- **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. It also puts rural hospitals and the patients they serve under severe stress, as low patient volume leaves these providers with more limited cash flow and less 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. Specifically, they have discussed allowing many more physician-owned hospitals to open and permit unfettered growth of existing physician-owned hospitals. This 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 major purchasers of drugs, face significant resource constraints and trade-offs as spending on drugs continues to increase at unsustainable rates. The primary driver behind increased drug spending is higher prices set by drug companies, not increases in utilization. We see both higher launch prices for new drugs and significant increases in prices for existing drugs. Limited generic and biosimilar competition, as well as increased occurrences of 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 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 (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 is facing major transformation. For several years, long-term care hospitals (LTCHs) have been transitioning to a new, two-tiered payment system, which has led to a reduction in aggregate patient volume, significant operational adjustments, and numerous closures. Also, in 2020 the Medicare prospective payment systems (PPS) for skilled nursing facilities (SNF) and home health (HH) agencies will be completely redesigned. In addition, the inpatient rehabilitation facility (IRF) PPS will face major reforms. Further, MedPAC continues to urge Congress to accelerate the implementation of a new, unified payment system for all four PAC settings. Collectively, the magnitude of these changes means that these providers and their patients are facing an overwhelming amount of 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 allowing these in-process changes to first be implemented and evaluated.

- **Underpayment of LTCH Site-neutral Cases.** The implementation of site-neutral payment for lower-acuity LTCH cases, as mandated by the Bipartisan Budget Act of 2013, is causing a major upheaval in the field. Site-neutral cases, which account for 36 percent of all cases, are paid a far lower inpatient PPS-comparable rate. However, AHA analyses indicate that these cases 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. Moreover, Medicare payments are falling short of the cost of care for these site-neutral cases, and only would cover 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

- **Support Building Coordinated Systems of Care.** 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 the Department of Justice, 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, which would help rebalance the merger review process.

- **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 the Administration to adopt regulations for the Stark and Anti-Kickback laws to protect clinical integration arrangements so that hospitals and physicians can work together to achieve a value-based system of coordinated care and improved patient outcomes. The AHA will also continue to urge Congress to eliminate compensation from the Stark Law, to return its focus to governing ownership arrangements, and allow Anti-kickback law to govern all compensation relationships.

- **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 of 2018 expanded Medicare coverage for telestroke and provided waivers in some alternative payment models, and that the CY 2019 Physician Fee Schedule Final Rule provided coverage and reimbursement for some care delivered via communications-based technology, 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 AHA urges Congress to further expand telehealth capacity by supporting programs 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-around, 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 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, created 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 continue to 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 smaller hospitals 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 Effectiveness 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, hospitals serve as beacons of hope for individuals and entire communities, providing essential care in the most trying of circumstances. Congress recognized that role in the Pandemic and All Hazards Preparedness Act (PAHPA) by creating the Hospital Preparedness Program (HPP), the primary federal funding program for emergency preparedness. Since 2002, the HPP has provided critical funding and other resources to aid hospitals' response to a wide range of emergencies. These investments have contributed to saving lives during many events, from the Las Vegas mass shooting to the Ebola crisis and recent natural disasters in Florida, California, North and South Carolina and Nebraska. 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 funded at a sufficient level. As such, we urge Congress to appropriate at least \$515 million annually for the HPP, doubling its current level of appropriated funding. This investment would help prepare and equip our health care system nationwide to respond to future disasters and public health emergencies. In addition, the AHA urges Congress to expeditiously pass the Pandemic and All-Hazards Preparedness & Advancing Innovation Act (H.R. 269), which overwhelmingly passed the House of Representatives in January, as it would reauthorize the HPP and the Public Health Emergency Preparedness Program.

We continue to 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.** New and chronic shortages of critical drugs are among the biggest challenges facing patients and hospitals. They threaten the quality of patient care, affect treatment options, and often require the use of alternative products that may be less appropriate/effective for the patient and/or less familiar to clinical staff, which can increase the potential for medical errors. Drug shortages also increase costs to hospitals and health care systems by diverting staff away from direct patient care in order to manage shortages, by substituting more expensive drugs or therapies for the shortage drugs, and by requiring adjustments to the management and documentation of the EHR. Moreover, drug shortages pose a threat to the public's health and to national security by decreasing the preparedness and resilience of health care systems and

communities for public health emergencies. 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. 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.

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 and 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, and more effective integration of behavioral health with physical health, including altering 42 CFR Part 2 to prevent errors by allowing all appropriate treating clinicians to be aware of a patient’s behavioral health diagnoses and treatments.

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. 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.** While Congress and HHS have made significant strides in addressing opioid misuse and overdoses, new and innovative approaches are needed to truly stem the tide of this national crisis. Inappropriate prescribing of opioid substances has decreased, but people who suffer from opioid- and other substance-use disorders need more support in their recovery.

The AHA encourages Congress to continue to enhance access to evidence-based treatment for substance-use disorder and to strengthen prescription drug monitoring programs and prescriber education through medical and dental school training. Additionally, the AHA supports the development of treatment models that reimburse for services beyond immediate stabilization including community-based recovery.

- **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 continues 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. The AHA will also advocate for advanced illness management to better honor patients' wishes at the end-of-life and for the government to remove barriers to expanding access to palliative care services.

- **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 and promoting efforts to share practices that have successfully helped to reduce or eliminate disparities in outcomes.

- **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 continues 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 to use the evolving science around the best ways to adjust for social risk factors to update its approach as needed.

- **Patient Safety.** Hospitals and other health care organizations recognize their responsibility to ensure patients receive high-quality care during the course of their treatment. America’s hospitals 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 the use of information technology. While information technology can enable better diagnosis, better communication of critical information and better analysis of factors common to errors or undesired outcomes, technologies can also contribute to the occurrence of errors as described in a 2015 Sentinel Event Report published by The Joint Commission.

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. AHA fully supports continued enforcement of the Patient Safety Act and its provisions that enable the health care community to learn from each other’s mistakes so that we can enhance the safety of everyone’s care. Further, AHA strongly supports the continued investment of CMS and other agencies in collaborative efforts to support the adoptions of safety improving strategies.

- **Hospital Star Ratings.** As longstanding supporters of transparency, America’s hospitals and health systems believe that patients, families and communities should have valid and clear quality information to help them make important health care decisions. Unfortunately, one of CMS’s laudable goals with star ratings – to give a meaningful, simplified view of hospital quality to consumers – is being compromised by a methodology that can lead to inaccurate, misleading comparisons of quality performance. The AHA appreciates that CMS continues to explore ways of improving star ratings. But, unless and until the ratings methodology is improved, it will be difficult for hospitals and the public to have confidence that star ratings portray hospital performance accurately.

The AHA urges the Administration to suspend the star ratings from the Hospital Compare website while its important work to improve the ratings continue. The agency should work with all stakeholders to develop a more conceptually sound approach to giving patients useful information.

PROMOTE REGULATORY RELIEF

- **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 an excessive number of conflicting, overlapping measures in Medicare reporting and pay-for-performance programs can 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. The AHA applauds CMS’s adoption of its “Meaningful Measures” framework, which resulted in the removal of a significant number of measures across its reporting programs in 2018. At the same time, work remains to remove measures that are no longer valuable, and to address high-priority gaps in measurement.

The AHA is working with stakeholders to advance streamlined, prioritized quality reporting requirements across payers and programs 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 PAC 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 (eCQMs) 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 eCQM measure, they find that the eCQM does not yield the same result. CMS recently proposed to continue the eCQM reporting requirements, but will remove seven of the 15 eCQMs 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 eCQMs, improve eCQMs so they are specified in a manner that permits accurate data collection from electronic records whenever possible and include eCQMs 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 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. Further, in a recently released rule, CMS proposes requiring as a Condition of Participation (CoP) that hospitals transmit admission, discharge and transfer notices to the patient's payer, the primary care physician and next site of care.

The AHA supports the use of health IT to improve the efficient, effective delivery of care. However, AHA believes the aggressive timelines set for the promoting interoperability program and unwavering focus on pushing hospitals to achieve interoperability without recognizing the essential role of other organizations in achieving it is a mistake. In particular, AHA strongly opposes including a requirement for interoperability in the COPs.

- **Accreditation Standards and Medicare CoPs.** Well-designed quality standards help health care delivery systems provide safe, effective care. However, flawed standards design, standards that are unclear, and poorly executed surveys can create burden without advancing safety and quality. As our study of regulatory burden shows, compliance with the Medicare CoPs require a substantial personnel and financial investment by hospitals. Hospitals strive to be fully compliant

with all of the requirements at all times, but that effort is made more difficult and burdensome if the requirements lack clarity or conflict with those 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 constantly strive to better coordinate care for patients, it is becoming increasingly clear that many standards may be antiquated and unnecessary or may need significant updates. Further, developments in health care delivery demonstrate that the current siloed approach to regulating hospitals and other care delivery organizations may no longer be the right path forward. Many healthcare providers no longer function as separate and distinct from the other providers caring for patients, nor should they. Moving forward, standards and requirements must recognize and support the movement toward increased coordination of health care delivery, which ultimately is in the best interest of 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. AHA is also urging CMS to provide clear and consistent guidance to its surveyors that is consistent with the CoPs, including updated guidance on co-location of health care facilities and the expectations for hospitals in protecting patients from ligature risks. AHA believes this guidance should be clear, straightforward and based on the science.

- **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 2019 (S. 895) 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. In the inpatient PPS final rule for FY 2018, CMS indicated its contractors will make reviews of this issue a “low priority.” While we appreciate CMS’ recognition of this barrier to care, 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 supports the Critical Access Hospital Relief Act of 2019 (H.R. 1041), which would remove the statutory 96-hour physician certification requirement as a condition of payment for CAHs.

- **Prior Authorization.** IRFs play a distinct role in the continuum of care, serving patients requiring hospital level care in combination with intensive therapy. Congress and CMS have in place extensive admissions criteria and program integrity oversight to ensure IRFs are caring for a high-acuity population. Despite these safeguards, the HHS released a September 2018 report that recommended an IRF prior authorization demonstration. However, the report findings are inconsistent with those of other CMS auditors. For example, an independent auditor’s re-review of a 2018 OIG audit of a specific IRF found a 50 percent error rate in the OIG’s findings – an egregious rate that calls into question their knowledge of IRF coverage rules. Further, IRFs’ successful appeal rate challenges the validity of the report, which did not account for these overturned denials. Moreover, the extrapolation of the report findings to all IRF claims, despite the limitations of the audits and report, appears to be a great over-reach.

The AHA opposes implementation of prior authorization for IRFs, which would impose a substantial access challenge to their high-acuity patients, such as individuals recovering from strokes, brain injuries, spinal cord injuries and other complex injuries, who need specialized IRF services. In addition, prior authorization could have the counterproductive effect of increasing costs and reducing outcomes by preventing timely hospital discharges and impeding care coordination. CMS should instead focus on ensuring patient-centered, transparent and reliable oversight of IRFs.

- **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 high insurance costs and risk of litigation affect physicians' willingness to continue providing services. The Congressional Budget Office and others have found that reforms could save \$50 billion over 10 years, depending on the policies implemented.

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.

- **Recovery Audit Contractors (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.

STRENGTHEN THE WORKFORCE

- **Medicare Graduate Medical Education (GME).** 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 pass the Resident Physician Shortage Reduction Act of 2019 (S. 348/H.R. 1763) to help alleviate the critical shortage of physicians. This legislation would add 3,000 Medicare-funded residency positions each fiscal year for the next five years, at least half of which must be used for a shortage specialty residency program.

- **Children's Hospitals Graduate Medical Education (CHGME).** The 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 in 2018 for an additional five years. 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 subspecialists, 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 GME program, CHGME is funded through annual appropriations. The program has enjoyed broad congressional support since its inception and is currently (FY 2019) funded at \$325 million.

The AHA supports funding the CHGME program in FY 2020 at \$400 million.

- **Scope of Practice Laws.** Predictions all point to a growing and severe primary care physician shortage in the decade ahead. Nurse practitioners (NPs), midwives and physician assistants (PAs) have helped to address provider workforce shortages. Estimates suggest that NPs and PAs account for 19 percent and 7 percent, respectively, of the primary care workforce and contribute substantially to the total supply of primary care visits.¹ However, many state licensure laws limit the ability of advanced practice clinicians to practice at the top of their license, thus limiting the services they may offer to patients. Additionally, physician supervision regulations have the potential to hinder maximum use of advance professional staff.

The AHA urges 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. And especially in rural communities, targeted programs that help address workforce shortages should be supported and expanded.

- **Workforce Development Programs.** Title VII health professions and Title VIII nursing workforce development programs, authorized under the Public Health Service Act and administered by HRSA, provide education and training opportunities for critical health disciplines and financial aid to health professions students. This is accomplished through loans, loan forgiveness and scholarships to students, as well as grants and contracts to academic institutions and nonprofit organizations. Title VII and VIII programs ensure the nation is equipped with a workforce that is reflective of the population it serves, while providing coordinated, high-quality care and improving access to care for all populations.

Title VII specifically includes programs to expand primary care in medicine and dentistry, increase the representation of minority and disadvantaged students in the health professions, and provide for the compilation and analysis of data on the nation's health workforce. Title VIII programs are directed exclusively to support the nursing profession to provide for the supply of professional nurses for practice in rural and medically underserved communities. Title VIII programs include Advanced Nursing Education; Nurse Workforce Diversity; Nurse Education, Practice, Quality and Retention; NURSE Corps; and the Nurse Faculty Loan Program.

The AHA supports the Reauthorization of Title VIII Nursing Workforce Development Programs (H.R. 728) and the adequate funding of Title VII health professions and Title VIII workforce development programs funded under HRSA.

- **Advancements in Technology and the Changing Role of Providers.** Many factors including technology, changing demographics, consumerism and shifts in practice will transform the way in which health care is delivered and the jobs required to provide care. A well-trained and nimble provider workforce with both the skills and receptivity for technology and data will be critical to

match the current and future pace of health care innovation. Health care leaders are encouraged to think comprehensively about these looming changes. The AHA, through its long-range policy planning efforts, seeks to elevate this issue and further explore the policy and operational implications for hospitals and health systems.

Beginning summer 2019, the AHA will convene leaders from member hospitals and health systems to provide input on the challenges, benefits and considerations of using technology to augment care, such as telemedicine, artificial intelligence/machine learning and robotics. This is a priority issue area for the AHA.

- **Violence Prevention.** Federal data show that workers in health care facilities experience higher estimated rates of non-fatal workplace violence than workers overall. Hospital and health systems are focused on violence prevention within their facilities and in the communities they serve. They depend on compassionate, committed, skilled and trained staff to advance their mission to care for sick individuals. They view the welfare and safety of employees as a priority issue, and take seriously their responsibilities to ensure a safe workplace void of all forms of violence. The efforts of the AHA cross-association Hospitals Against Violence initiative is reflected in the development of tools, educational resources and dissemination of leading practices to combat violence in hospitals and their communities. At the hospital and health systems level, many have established organization-wide initiatives aimed at addressing workplace violence.

The AHA is supportive of and committed to helping the nation’s hospitals and health systems meet the ongoing challenge of violence prevention and reduction.

- **Clinician Resiliency.** Clinician resiliency is tied to many factors, including regulatory burden and increased documentation requirements, which overwhelm providers and divert their attention from patient care. Reducing regulatory requirements will allow providers to focus on patients, not paperwork. Through its Patients over Paperwork initiative, CMS along with key stakeholders and partners (including the AHA), will evaluate and streamline regulations with a goal to reduce unnecessary burden, increase efficiencies and improve the beneficiary experience.

The AHA will continue to work with the Administration to address clinician burden through its payment rules and quality measures program.

- **Workforce Diversity and Health Equity.** The AHA, through its subsidiary, The Institute for Diversity and Health Equity, conducts many initiatives related to advancing cultural competence and diversity. These actions include, Summer and Fall Enrichment programs for diverse graduate

students in health care administration, Certificate in Diversity Management, Diversity Dialogues – webinars and training addressing cultural competency, establishing a culture of health equity, and creating a culture of diversity and inclusion, trustee match program – strategic alliance with UnidosUS and the National Urban League, and Virtual Expeditions, which consists of five learning modules that help clinicians address social determinants of health within a framework that maximizes their skills. Cultural competency is a resonant concept throughout the modules. These examples reflect the AHA’s commitment to diversity and health equity in the health care workforce.

The AHA supports the hospital and health systems field in efforts to reduce health care disparities, promote diversity and cultural competency in the health care workforce.

SOURCES

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American Hospital
Association®

Advancing Health in America

CHICAGO OFFICE

155 N. Wacker Drive
Suite 400
Chicago, IL 60606-1725
312-422-3000

WASHINGTON OFFICE

800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
202-638-1100

WWW.AHA.ORG



@AHAADVOCACY



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