

**Statement
of the
American Hospital Association
before the
Health Subcommittee
of the
Energy and Commerce Committee
of the
U.S. House of Representatives**

“A Permanent Solution to the SGR: The Time Is Now”

January 22, 2015

On behalf of the American Hospital Association’s (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, thank you for the opportunity to testify today and provide the hospital perspective on ways to pay for fixing the deeply flawed Medicare physician payment formula.

Ensuring that physicians receive adequate reimbursement for care provided is important for patients and hospitals, and we support permanently replacing the Medicare sustainable growth rate (SGR) for physician payment. We commend the members of the House and Senate committees of jurisdiction that last year unveiled legislation to fix the recurring physician payment problem by repealing the SGR formula. The bipartisan, bicameral SGR Repeal and Medicare Provider Payment Modernization Act (H.R. 4015) would provide physicians a 0.5 percent payment update for five years, while encouraging physicians to transition away from fee-for-service to new payment and delivery system models based on value. This thoughtful legislation would also: consolidate the current-law physician quality reporting system, electronic health record and value-based modifier programs into one; incentivize physician participation in alternative payment models; incentivize care coordination efforts for patients with chronic care needs; and expand the use of Medicare data for transparency and quality improvement. The bill,



however, did not include suggestions regarding how to cover the cost of these proposals. The AHA cannot support any proposal to fix the physician payment problem at the expense of funding for services provided by other caregivers.

Congress needs to move away from cutting funding for services provided by other caregivers to pay for the physician fix. Offsets should not come from other health care providers, including hospitals, who are themselves working to provide high-quality, innovative and efficient care to beneficiaries in their communities and are being paid less than the cost of providing services to Medicare beneficiaries. For example, in fiscal year (FY) 2015, the Medicare Payment Advisory Commission (MedPAC) projects that the average hospital will have an overall Medicare margin of negative 9.0 percent.

Today, market forces and significant reforms in both the public and private sectors are actively reshaping America's health care delivery system. As hospitals are adapting to the changing health care landscape, they are increasingly partnering and aligning with clinicians to help achieve the Triple Aim of enhancing the patient experience, improving the health of populations and reducing the per-capita cost of health care. In 2013, hospitals employed about a third of the nation's physicians – more than 107,000 full-time doctors and dentists, as well as more than 105,000 full-time medical and dental interns and residents – and this number is growing rapidly. To reduce hospital payments to prevent physician cuts is, therefore, counterproductive and would adversely impact the very physicians Congress is trying to help. When there is greater physician-hospital alignment, providers are able to more aggressively redesign the way health services are delivered to achieve efficient and high-quality patient outcomes.

Yet hospitals' ability to maintain the kind of access to care their patients and communities expect is further threatened by repeated ratcheting down of payments for Medicare and Medicaid hospital services to pay for other priorities. Hospitals have faced more than \$121 billion in cuts since 2010 alone. Additional cuts to Medicare and Medicaid funding for hospital services would mean: longer wait times for care; fewer doctors, nurses and other caregivers; and less patient access to the latest treatments and technology.

Recognizing that the AHA cannot simply oppose hospital cuts without supporting other solutions, we would like to highlight policy changes to Medicare where Congress could both have an impact on Medicare's finances and pay for a permanent Medicare physician payment fix. Our recommendations are similar to ideas that have received bipartisan support from a number of commissions, lawmakers and the administration. The year 2015 marks Medicare's 50th anniversary. It is time to make significant, structural reforms to this crucial benefit to ensure its sustainability for all seniors for the next 50 years, and beyond.

ENSURING A HEALTHIER TOMORROW

While the rate of health care spending is at an all-time low, changing demographics, the aging of the baby boom generation, the growth in chronic illness, advances in medical technology and other factors will challenge the ability to achieve a sustainable level of health care spending – especially for Medicare and Medicaid.

While traditionally the federal government has turned to cutting Medicare and Medicaid spending, almost exclusively through provider payment reductions, this will not put us on a sustainable path for the future. Numerous studies have found – and the flawed physician SGR confirms – that reducing provider payment rates does not result in reduced Medicare spending on services. Rather, we need targeted reforms for our health care system. Every stakeholder – providers, the government, insurers, employers and individuals – bears some responsibility and everyone must contribute to the solution.

The AHA recommends taking steps to promote and reward accountability and use limited health care dollars wisely. Our recommendations are laid out in a 2012 report, “Ensuring a Healthier Tomorrow: Actions to Strengthen Our Health Care System and Our Nation's Finances” (a copy of the report is attached).

These recommendations are not exhaustive, but a starting point of initiatives stakeholders can take together. There are many actions providers need to pursue, and hospitals are working on those areas within our span of control – for example, seeking to eliminate preventable infections and complications, as well as eliminating non-value-added treatments. And we are making real progress. Study after study confirms that hospitals are improving the quality and equity of care they deliver and are improving in their efforts to keep patients safe. Just last week, the Centers for Disease Control and Prevention announced that hospitals reduced central-line associated blood stream infections (CLABSI) and surgical site infections by 46 percent and 19 percent, respectively, between 2008 and 2013. Among other improvements, hospitals reduced *C. difficile* infections by 10 percent and methicillin-resistant *staphylococcus aureus* infections by 8 percent between 2011 and 2013.

The AHA’s Health Research & Educational Trust affiliate directed a national project to reduce CLABSIs through the Comprehensive Unit-based Safety Program (CUSP) and is currently administering a CUSP program and fellowship to prevent catheter-associated urinary tract infections, as well as directing the largest of the nation’s Hospital Engagement Networks. Similarly, provider-led initiatives like our Physician Leadership Forum’s Appropriate Use of Medical Resources series and the ABIM Foundation’s Choosing Wisely campaign are working to better educate providers and consumers on appropriate treatment selection. Efforts like these are having a dramatic impact on health care quality and cost. In fact, the growth of health care spending has fallen to the lowest rate since the federal government began tracking it half a century ago.

Below are several actions Congress could take that would not only generate savings, but also put the Medicare program on firmer financial footing for years to come.

Modernize Medicare by Combining Parts A and B with a Unified Deductible and Co-insurance. In traditional Medicare, beneficiaries’ hospital and acute care coverage (Part A) are separate, and have a separate cost-sharing structure, from physician and outpatient services (Part B). For example, enrollees who are hospitalized must pay a Part A deductible (\$1,260 in 2015) for each “spell” of illness for which they are hospitalized; in addition, they are subject to daily copayments for extended stays in the hospital and for skilled nursing care. Meanwhile, the

annual deductible for outpatient services is covered under Medicare's Part B (\$147 in 2015). Beyond that deductible, enrollees generally pay 20 percent of allowable costs for most Part B services. At the same time, certain services that are covered by Medicare, such as home health visits and laboratory tests, require no cost sharing. As a result of those variations, enrollees have conflicting incentives to weigh relative costs when choosing among options for treatment. Moreover, if Medicare patients incur extremely high medical costs, they can face a significant amount of cost sharing because the program does not cap those expenses.

This proposal, as described by the Congressional Budget Office (CBO), would replace the current complicated mix of cost-sharing provisions with: first, a single combined annual deductible covering all services in Parts A and B of Medicare; second, a uniform coinsurance rate of 20 percent for amounts above that deductible (including inpatient expenses); and, third, an annual cap on each enrollee's total cost-sharing liabilities. Under this option, CBO estimated the combined deductible would be \$550, and the cap on total cost sharing would be \$5,500.

Modernizing Medicare in this way would provide greater protection against catastrophic costs while reducing Medicare's coverage of more predictable expenses. Capping enrollees' out-of-pocket expenses would especially help people who develop serious illnesses, require extended care, or undergo repeated hospitalizations but lack some supplemental (Medigap) coverage for their cost sharing. It also would increase incentives for enrollees to use medical services prudently. Deductibles and coinsurance rates expose beneficiaries to the financial consequences of decisions about health care treatments and are aimed at ensuring that services are used only when an enrollee's benefits exceed those costs. The uniform coinsurance rate across services would also encourage enrollees to compare the costs of different treatments in a more consistent way. In addition, the reductions in costs under this option for Medicare's Part B program would translate into lower premiums for all enrollees. Under this option federal outlays would be reduced by \$52 billion over 10 years, CBO estimates.

Of course, any changes to Medicare beneficiaries' cost-sharing must account for income differences and be phased in to limit the impact on vulnerable populations.

The administration, in its annual budget, has also proposed increased beneficiary cost sharing, such as increased Part B deductibles for new Medicare beneficiaries. The AHA agrees with the administration's position in the budget that Medicare cost sharing "helps to share responsibility for payment of Medicare services between Medicare beneficiaries," and that increased cost sharing will serve "to strengthen program financing and encourage beneficiaries to seek high-value health care services" Ultimately, specifics on the structure of cost-sharing changes can be deliberated, and the AHA is open to the administration's proposals; but it is important to note the program financing and shared responsibility for value that is discussed in the president's budget.

Modifications to First-dollar Medigap Coverage. About 25 percent of enrollees in fee-for-service Medicare purchase Medigap policies, and about 40 percent have retiree coverage through a former employer. By reducing or eliminating enrollees' cost-sharing obligations, those policies can, at times, mute the incentives for prudent use of medical care that cost sharing is designed to generate. The administration agrees with this dynamic – the president's 2014 budget stated:

“Medicare requires cost-sharing for various services, but Medigap policies sold by private insurance companies provide beneficiaries with additional coverage for these out-of-pocket expenses. Some Medigap plans cover all or almost all copayments, including even modest copayments for routine care that most beneficiaries can afford. This practice gives beneficiaries less incentive to consider the cost of services, leading to higher Medicare costs and Part B premiums.”

There are various proposals for improving incentives under Medigap. One suggestion from CBO would bar those Medigap policies from paying any of the first \$550 of an enrollee’s cost-sharing obligations and would limit their coverage to 50 percent of the next \$4,950 of an enrollee’s cost sharing (Medigap policies would cover all further cost sharing, so policyholders would not pay more than \$3,025). Under this option, federal outlays would be reduced by \$58 billion over 10 years, CBO estimates.

The president’s proposal is structured differently, but addresses the same Medigap dynamics. The president’s plan “would introduce a Part B premium surcharge for new beneficiaries who purchase Medigap policies with particularly low cost-sharing requirements, effective in 2017. Other Medigap plans that meet minimum cost-sharing requirements would be exempt from the surcharge. The surcharge would be equivalent to approximately 15 percent of the average Medigap premium.” Specifics on the structure of first-dollar Medigap changes can be discussed and determined by the Congress, and the AHA is open to the administration’s and CBO’s proposals.

Increasing Income-related Premiums under Medicare. All enrollees in Part B or Part D of Medicare are charged basic premiums for that coverage. Those premiums are currently \$104.90 per month for Part B and an average of \$31.17 per month for Part D. When the Part B program began, in 1966, the basic premium was intended to cover 50 percent of Part B costs per enrollee over age 65.

Enrollees in Parts B and D who have relatively high income pay a higher premium known as the income-related premium (IRP). The amount of the IRP depends on an enrollee’s modified adjusted gross income, or MAGI (the total of adjusted gross income and tax-exempt interest). The AHA supports proposals that contemplate changes to premiums to ensure the long-term health of the Medicare program, and we believe this is apropos of this discussion to consider this option to pay for fixing the physician payment issue because significant cuts to Medicare physician payments under current law represent a significant challenge to the health of Medicare. CBO has published an analysis on raising beneficiary premiums from paying for 25 percent of Part B costs (a change made in 1997) to 35 percent. The administration in its 2014 budget proposed doing this based on Medicare beneficiary income, and this is another approach the AHA believes Congress should explore. This proposal would help improve the financial stability of the Medicare program by reducing the federal subsidy of Medicare costs for those beneficiaries who can most afford them. Under this option, federal outlays would be reduced by \$52 billion over 10 years, the Office of Management and Budget estimates.

Some of our members have discussed the concept of raising the Medicare eligibility age. Such an increase would be similar to increases currently scheduled under the Social Security program,

and account for increases in life expectancy. However, some policymakers have raised objections to this approach. In an effort to promote bipartisan structural reforms to the Medicare program, we are not recommending Congress incorporate such a change in the SGR deliberations. However, we encourage Congress to continue to discuss the eligibility age as people live longer and healthier lives.

Reform the Medical Liability System. Hospitals and physicians continue to face skyrocketing costs for professional liability insurance. This is affecting access to care as physicians leave states with high insurance costs or stop providing services that expose them to higher risks of lawsuits. This also often leads clinicians to practice “defensive medicine” – providing extra, often unnecessary, care to minimize the risk of lawsuits. Steps the government could take include: establishing “safe harbor” protections for providers who follow evidence-based clinical practice guidelines; capping non-economic damages; allowing courts to limit lawyers’ contingency fees; and providing prompt compensation to injured patients based on an agreed-upon payment schedule. Under these options, federal outlays would be reduced by \$57 billion over 10 years, CBO estimates.

Simplify Administrative and Regulatory Processes. Providers face duplicative regulations and high compliance burdens, as well as varying claims-processing and record-keeping requirements, imposed by the array of public and private insurance plans. Care can be more affordable if health care professionals spend more time at the bedside and less time on paperwork. Insurers and employers also want to reduce administrative costs. The Center for American Progress estimated that administrative costs consume 14 percent of all health care expenditures and that at least half of this spending is wasteful. Its analysis found that reducing the administrative complexity of health care could save \$40 billion annually. Additional cost savings could be achieved through regulatory relief, such as limiting and better coordinating the flood of new and often overlapping auditing programs that are burdening providers with duplicative audits, unmanageable medical record requests and inappropriate payment denials.

No one questions the need for auditors to identify fraud or correct billing mistakes; however, the multiplicity of federal, state and private payer programs are resulting in unnecessary costs and burdens. Similarly, the many credentialing and quality improvement initiatives established by regulators, private accreditors and payers have conflicting and overlapping requirements that make care delivery more expensive. CBO has not scored this proposal.

The stakes are high, and the time to act is now. These actions would help to dramatically bend the cost curve, saving billions of dollars for taxpayers.

CUTS TO HOSPITAL PAYMENTS NOT THE ANSWER

Funding for hospital services provided to Medicare beneficiaries continues to fall below the actual cost of providing care. Recognizing this, last week, MedPAC recommended increasing hospital inpatient and outpatient Medicare prospective payment system (PPS) payments in FY and calendar year (CY) 2016, respectively. These are the same recommendations the commission

approved for FY 2015. Specifically, the commission recommended increasing payment rates for the acute-care hospital inpatient and outpatient PPSs by 3.25 percent.

In FY 2015, MedPAC projects that the average hospital will have an overall Medicare margin of negative 9.0 percent. Hospitals continue to face ongoing cuts mandated by Congress, including sequestration, the documentation and coding cuts set forth in the American Taxpayer Relief Act (ATRA) and additional penalties associated with quality reporting and compliance with meaningful use requirements. In total, hospitals have faced more than \$121 billion in cuts since 2010.

Now is not the time to further cut payments to hospitals. Below we outline several proposals that, if implemented, would have a devastating effect on hospitals' ability to continue delivering the high-quality, accessible care upon which their communities depend. We urge Congress to reject these proposals as it considers ways to pay for replacing the SGR formula.

Implementation of Site-neutral Payment Policies. Some in Congress have suggested adopting an ill-advised proposal that would cap "total" payment for non-emergency department evaluation and management (E/M) services in hospital outpatient departments (HOPDs) at the rate paid to physicians for providing the services in their private offices. MedPAC had estimated its policy would reduce Medicare spending by \$900 million per year and \$9 billion over 10 years by reducing hospital payment between 65 percent and 80 percent for 10 of the most common outpatient services.

The AHA strongly opposes such legislation because:

- Hospitals provide access to critical hospital-based services that are not otherwise available in the community and treat higher-severity patients for whom the hospital outpatient department is the appropriate setting.
- Hospitals have higher cost structures than physician offices due to the need to have emergency stand-by capacity.
- Hospitals have more comprehensive licensing, accreditation and regulatory requirements than physician offices.

In addition, some in Congress have proposed capping total payment for certain HOPD services at the physician rate. MedPAC estimates that this would cut hospital outpatient payments by 2.7 percent, or \$1.2 billion, in one year. The services in these 66 ambulatory payment classifications (APCs) are outpatient services that are integral to hospitals' service mission. However, MedPAC identified them as candidates for site-neutral cuts because a MedPAC staff analysis showed that they met several criteria, including being frequently performed in physician offices. The policy would result in steep cuts. For instance, using data reflecting 2013 APC packaging policies, the hospital's payment for a level II echocardiogram without contrast (APC 0269) would drop from \$390.49, the average amount paid in 2013 under the outpatient PPS, to \$125.91 – a 68 percent reduction.

However, in recent years, CMS has been shifting the OPSS more definitively away from a per-service fee schedule to a prospective payment system with larger payment bundles. As this shift

occurs, the package of services paid under the OPSS will become less comparable to those paid under the PFS, meaning the implementation of site-neutral payment policies will more likely result in unfair and inaccurate payments. Further, larger payment bundles provide incentives to improve efficiency and better manage resources – site-neutral payment policies will hamper this innovation. Steep payment cuts could have unintended consequences for patient access to care and hospitals’ ability to continue to provide emergency standby services.

Additionally, MedPAC proposed an alternate site-neutral proposal that would base payments for HOPD services on the rates Medicare pays for services in ambulatory surgical centers (ASCs). The impact of this approach also would be significant; currently, Medicare pays for covered surgical services in ASCs at approximately 60 percent of the rate that it pays for similar services in the HOPD. This policy would reduce HOPD payment for 12 APCs that are commonly performed in ASCs to the ASC level. MedPAC estimates that this policy would reduce hospital outpatient payment by \$590 million per year or a 1.7 percent decrease.

The AHA strongly opposes these cuts. Unlike physician offices and ASCs, hospitals play a unique and critical role in the communities they serve by providing a wide range of acute-care and diagnostic services, supporting public health needs and offering many other services that promote the health and well-being of the community. In addition, hospitals provide emergency standby services such as:

- 24/7 Access to Care: Providing health care services, including specialized resources, 24 hours a day, seven days a week, 365 days a year.
- The Safety Net: Caring for all patients who seek emergency care regardless of ability to pay.
- Disaster Readiness and Response: Ensuring that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions.

As a part of this 24/7, safety-net and readiness, hospitals must have surgical capabilities for extremely complex patient cases, and do not enjoy the ASC capability to only prepare for the least complex outpatient cases. This high level of hospital capability must be accounted for in reimbursement.

Despite its importance, hospitals’ standby role is not explicitly funded. There is no payment for a hospital and its staff to be at the ready until a patient with an emergency need arrives. Without such explicit funding, the standby role is built into the cost structure of full-service hospitals and supported by revenue from direct patient care – a situation that does not exist for physician offices, ASCs or any other type of provider. Indeed, hospitals today face challenges in maintaining this standby role, such as staffing and space constraints, greater expectations for preparedness, the erosion of financial support from government payers and the loss of patients to other settings that do not have the added costs of fulfilling the standby role. In addition, some physicians and ASCs do not serve Medicaid and charity care patients. By contrast, hospitals provided \$46 billion of uncompensated care in 2012.

The critical roles that hospitals play, while often taken for granted, represent essential components of our nation's health and public safety infrastructure. It is critical that Congress consider these unique roles of hospitals and refrain from imposing site-neutral payment cuts on HOPD services.

Reductions to Assistance to Low-income Beneficiaries. The Medicare program requires its beneficiaries to pay a portion of the cost of their care, for example, through the inpatient hospital deductible of more than \$1,200 and through the outpatient hospital coinsurance of 20 percent. Many low-income beneficiaries cannot pay these amounts to the hospital, resulting in unpaid debt (sometimes referred to as "bad debt"). Historically, the Medicare program has reimbursed hospitals for a portion of the debt incurred by Medicare beneficiaries, particularly those with low incomes.

The Middle Class Tax Relief and Job Creation Act of 2012 reduced these payments for PPS hospitals from 70 percent to 65 percent beginning in FY 2013, and for critical access hospitals (CAHs) from 100 percent to 65 percent, phased-in over three years beginning in FY 2013. Thus, for CAHs, Medicare paid 88 percent of allowable bad debt in FY 2013, 76 percent in FY 2014, and will pay 65 percent in 2015 and beyond.

The AHA urges Congress to reject any cuts to hospital payments for assistance in covering the debts of low-income Medicare beneficiaries. The Medicare program already pays less than the cost of providing care to Medicare beneficiaries. Reductions exacerbate this problem, especially for those hospitals that serve many low-income beneficiaries, such as safety-net hospitals and rural hospitals: it leaves safety-net hospitals with less ability to serve low-income Medicare beneficiaries; and it 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. Rural hospitals have Medicare bad debt levels that are, on average, 50 percent higher than urban hospitals. Cutting reimbursement to hospitals for assistance to cover the debts of low-income Medicare beneficiaries while still paying less than the cost of care to Medicare beneficiaries is inappropriate.

Medicaid frequently underpays beneficiaries' Medicare cost-sharing obligations, leading to high levels of dual-eligible beneficiary debt. Dually eligible beneficiaries account for roughly 20 percent of Medicare beneficiaries, but about 59 percent of hospitals' Medicare bad debt.

Under Medicare's statutory reasonable cost principles, costs of care that are attributable to Medicare beneficiaries cannot be shifted to non-Medicare patients, and vice versa. Thus, when hospitals are unable to collect cost-sharing payments owed by Medicare beneficiaries, they record these payments as bad debt and are reimbursed a portion of that Medicare debt directly from CMS.

Reductions to Graduate Medical Education (GME). Some policymakers are advocating a significant reduction in Medicare GME payments to teaching hospitals. The president's FY 2015 budget called for reducing the indirect medical education (IME) adjustment by 10 percent, from 5.5 percent to 5.0 percent, which would cut Medicare medical education payments by approximately \$14.6 billion over 10 years. The Simpson-Bowles deficit commission

recommended reducing the IME adjustment by 60 percent and limiting hospitals' direct GME (DGME) payments to 120 percent of the national average salary paid to residents in 2010. The Simpson-Bowles changes would reduce Medicare medical education payments by an estimated \$60 billion through 2020.

In July, an Institute of Medicine (IOM) committee recommended phasing out Medicare's current, separate IME and DGME payments to hospitals and replacing them with one geographically adjusted national per resident amount, paid to GME training program sponsors. If implemented, the recommendations would uncouple Medicare GME funding from patient care provided to Medicare beneficiaries, allowing current hospital GME funding to go to other entities that do not treat Medicare patients and to the creation of additional government bureaucracies. According to the IOM committee's own projections, in year five of a 10-year phase out of Medicare GME funding, teaching hospitals would effectively experience a 35 percent cut in payment for GME. The committee recommends the termination of Medicare support at the end of 10 years with no new funding source – instead, simply an assessment of the ongoing need for Medicare funding. Finally, the recommendations do not adequately address the current limits on the number of Medicare-funded residency training slots when our nation is already facing a critical shortage of physicians. The report also ignores how hospitals are already addressing the changing health care landscape by: providing training in outpatient settings such as community clinics; giving a common infrastructure to support all residents; and recognizing that some specialties, like neurosurgery, require training only in an inpatient environment.

The AHA urges Congress to reject reductions in Medicare funding for IME and DGME. The nation is already facing a critical shortage of physicians, and cuts to IME/DGME would further exacerbate the problem. Experts indicate that the nation could face a shortage of as many as 130,000 doctors by 2025; the expansion of health care coverage would increase overall demand for physicians and increase the projected physician shortfall by up to 31,000 physicians. Physician shortages would hamper national efforts to improve access to care and may result in longer wait times for patients.

Cuts to GME funding would also jeopardize the ability of teaching hospitals to train the next generation of physicians. They would force teaching hospitals to eliminate staff, close training programs and eliminate services operating at a loss. In February 2011, the Association of American Medical Colleges estimated the impact of federal IME cuts and found that a 60 percent reduction in IME payments could mean a loss of 72,600 jobs, \$653 million in state and local tax revenue and \$10.9 billion to the U.S. economy.

Given the current and projected shortage of physicians, especially in primary care and general surgery, the AHA continues to recommend that the 1996 cap on residency slots be lifted. We urge Congress to eliminate the 18-year freeze in the number of physician training positions Medicare funds by supporting the creation of at least 15,000 new resident positions (about a 15 percent increase in residency slots) as included in the Resident Physician Shortage Reduction Act of 2013, introduced by Rep. Joseph Crowley (D-NY).

Changes to the CAH Program. Approximately 51 million Americans live in rural areas and depend upon the hospital as an important, and often the only, source of care in their community. Remote geographic location, small size and limited workforce, along with physician shortages and often constrained financial resources, pose a unique set of challenges for rural hospitals. Compounding these challenges, rural hospitals' patient mix makes them more reliant on public programs and, thus, particularly vulnerable to Medicare and Medicaid payment cuts.

Medicare and other federal programs need to account for the special circumstances of rural communities. This includes securing the future of existing special rural payment programs – including the critical access hospital, sole community hospital, Medicare-dependent hospital and rural referral center programs.

Some lawmakers, and the administration, have proposed changes to the CAH program that would have a detrimental impact on health care in many vulnerable rural communities. The AHA continues to advocate that Congress maintain current policies which provide vital funding for rural and small hospitals. This includes:

- ensuring CAHs are paid at least 101 percent of costs by Medicare Advantage plans;
- ensuring rural hospitals and CAHs have adequate reimbursement for certified registered nurse anesthetist services, including stand-by services;
- providing CAHs with bed-size flexibility;
- reinstating CAH necessary provider status; and
- removing unreasonable restrictions on CAHs' ability to rebuild.

In addition to their vulnerability to payment cuts and harmful changes to vital rural programs, small and rural hospitals are disproportionately affected by burdensome federal regulatory policies, threatening their ability to provide care to the patients and communities they serve. These regulatory burdens include the 96-hour rule, the outpatient therapeutic services direct supervision policy and the electronic health records and meaningful use regulations. CMS should better account for the unique circumstances of rural providers in the rulemaking process.

Changes to Post-acute Care Payment. In recent years, post-acute care providers have faced great scrutiny from Congress. More recently, the Bipartisan Budget Act of December 2013 (BiBA) implemented a site-neutral payment policy for LTCHs, which will reduce payments for one out of two long-term care hospital (LTCH) cases – a cut of \$3 billion. And the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) sets in motion for each of the post-acute settings a more consistent reporting infrastructure and the development of a consolidated post-acute payment system prototype.

In addition, the president's FY 2015 budget would lower inpatient rehabilitation facility (IRF) reimbursement for selected patients to a skilled nursing facility (SNF) level payment, and raise the current IRF "60% Rule" threshold. Similar proposals are anticipated in the president's FY 2016 budget. These proposals overlook clear distinctions between SNF and IRF patients and services, as mandated and documented by CMS. As a result of tougher Medicare standards, IRF case mix has increased and the number of IRF patients has dropped by 140,000 cases annually since 2004. IRFs help beneficiaries regain physical and cognitive function after major health

events such as strokes, brain injuries and spinal cord injuries. And they provide further value to the overall system of care with their low readmissions rate.

Independent Payment Advisory Board (IPAB). Created by the Affordable Care Act (ACA), IPAB is a commission appointed by the president and empowered to establish reimbursement rates for the Medicare program. Although hospitals will not be subject to IPAB decisions until 2020, we are concerned that removing elected officials from the decision-making process could result in even deeper cuts to the Medicare program in the future. The AHA supports the repeal of IPAB, because its existence permanently removes Congress from the decision-making process, and threatens the important dialogue between hospitals and their elected officials about how hospitals can continue to provide the highest quality care to their patients and communities.

Changes to the 340B Drug Pricing Program. Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to eligible public and non-profit health care facilities that care for large numbers of uninsured and low-income people. The program enables eligible entities, including certain hospitals, to stretch scarce federal resources to expand and improve access to comprehensive health care services to more patients in the communities they serve.

Since the program was established in 1990, Congress has acted several times to expand it. Currently, community health centers, children's hospitals, hemophilia treatment centers, critical access hospitals, sole community hospitals, rural referral centers and public and nonprofit disproportionate share hospitals that serve low-income and indigent populations are eligible to participate in the program. These entities must meet a variety of requirements to participate in the program, including: yearly recertification; audits from both the Health Resources and Services Administration (HRSA), which oversees the program, and drug manufacturers; and maintaining auditable inventories of all 340B and non-340B prescription drugs.

Hospitals that participate in the 340B program use the savings to provide enhanced services to their patients, including, but not limited to: funding other medical services, such as obstetrics, diabetes education, oncology services and other ambulatory services; providing financial assistance to patients unable to afford their prescriptions; providing clinical pharmacy services, such as disease management programs or medication therapy management; establishing additional clinics; creating new community outreach programs; and offering free vaccines.

The AHA opposes any efforts to scale back or reduce the benefits of the 340B program. The 340B program has a proven track record of decreasing government spending and helping safety-net providers stretch limited resources to increase access to care for the vulnerable patients and communities they serve. In addition, HRSA has undertaken many efforts to exert more oversight of the program. The AHA supports program integrity efforts to ensure this vital program remains available to safety-net providers and encourages HRSA to develop a process to help financially-distressed providers meet new program integrity provisions.

Restrictions on Medicaid Provider Assessments. The Medicaid provider assessments program has allowed state governments to expand coverage, fill budget gaps and maintain patient access to health services to avoid additional provider payment cuts by helping states finance their

portion of the joint federal/state program. Some policymakers have called for restricting states' ability to use assessments as a financing tool. The president's FY 2013 budget had proposed to phase down, but not eliminate, Medicaid provider assessments beginning in 2015. The administration estimated this would save \$21.8 billion over 10 years. The House approved its FY 2013 budget reconciliation package with cuts to Medicaid provider assessments of \$11.2 billion over 10 years. The Simpson-Bowles deficit commission also recommended restricting, and eventually eliminating, states' ability to use assessments on health care providers to finance a portion of their Medicaid spending. This proposal to eventually eliminate provider assessments would result in estimated reductions of \$44 billion in the Medicaid program by 2020.

The AHA urges Congress to reject options that restrict states' ability to partially fund Medicaid programs using provider assessments. Restrictions in the use of provider assessments are just another name for Medicaid cuts. Further cuts to funding for hospital services would put enormous pressure on already stretched state budgets and could jeopardize this critical health care safety-net program. Hospitals already experience payment shortfalls when treating Medicaid patients. Medicaid, on average, covers only 89 cents of every dollar spent treating Medicaid patients. Changes to the provider assessment program would further exacerbate this problem. Currently, 67 million low-income Americans rely on the Medicaid program to provide access to health care. With implementation of the ACA, as many as 13 million more people may be enrolled in Medicaid (based on April 2014 CBO estimates). Any reduction or elimination of Medicaid provider assessments would be on top of Medicaid cuts made at the state level.

CONCLUSION

The AHA and the hospital field appreciate your consideration of these issues. Real improvements in health and health care – as opposed to arbitrary cuts to provider payment – have the ability to put our country on a more sustainable fiscal path and have received bipartisan support. But reining in health care spending is only one part of the solution to our nation's fiscal crisis. And, hospitals are just one component of the health care system. Together, we need to create solutions that allow individuals to access the care they need, when and where they need it and have it delivered in the safest, most cost-effective manner. By focusing our efforts and taking responsibility for that which we can control, together we can ensure a healthier tomorrow.



American Hospital Association®

Ensuring a Healthier Tomorrow

*Actions to Strengthen Our Health Care System and
Our Nation's Finances*

Executive Summary

THE PROBLEM:

The current growth rate for health care spending is a central area of focus for policymakers. The growth in Medicare and Medicaid spending is contributing to the nation's debt and deficit. Today, Medicare costs about \$560 billion annually. And the Congressional Budget Office (CBO) projects spending will almost double over the next decade, totaling more than \$1 trillion by 2022. If health care spending is not slowed, the effects will be profound and affect everyone – health care providers, the government, insurers and employers, and individuals.

In times of fiscal crisis, the federal government repeatedly turns to cutting Medicare and Medicaid spending, almost exclusively through reducing provider payment. **But ratcheting provider payments will not put us on a sustainable path for the future; we need real targeted reforms, not blunt cuts to provider payment.**

THE SOLUTION:

As policymakers grapple to rein in Medicare and Medicaid spending, they should focus on the following two interconnected strategies that will improve the health care system, ensure the short- and long-term financial viability of these programs, and tackle the federal debt and deficit:

- **Promote and reward accountability.** We need to re-structure the system in a way that promotes and rewards accountability – to patients, their families and their communities—and ensures that all stakeholders are responsible and answerable for the quality, appropriateness and efficiency of health care provided.
- **Use limited health care dollars wisely.** We need to focus on using limited health care dollars more wisely—in ways that eliminate inefficiency and improve quality of care for patients.

This paper identifies a number of **recommended changes** necessary to achieve each strategy. Perhaps more importantly, it lays out an **action plan and priority checklist** for providers, the government, insurers and employers, and individuals. Everyone bears some responsibility and everyone must contribute to the solution.

STRATEGY 1: PROMOTE AND REWARD ACCOUNTABILITY

1. ***Accelerate Payment and Delivery System Reforms.*** Payment systems need to move away from fee-for-service toward integrated and innovative delivery models, such as medical homes, bundled payments and accountable care organizations (ACOs).
2. ***Eliminate Preventable Infections and Complications.*** Healthcare-associated infections and complications are among the leading causes of death and result in unnecessary health care costs. We must eradicate them.
3. ***Engage Individuals in their Health and Health Care.*** Unhealthy behavior, such as smoking, poor diet and sedentary lifestyles, accounts for up to 40 percent of premature deaths in the U.S. Involving patients in their health and health care is critical to improving wellness and health outcomes.
4. ***Better Manage Advanced Illness.*** We need to ensure that severely ill patients and their families are empowered to make health care decisions and have access to a comprehensive set of health care and social services.
5. ***Advance the Use of Health Information Technology and Electronic Health Records (EHRs).*** EHRs hold the promise of providing clinicians and patients with real-time access to medical information, which can improve medical decision-making, quality and patient safety. We need to standardize these technologies and achieve interoperability.
6. ***Promote Transparency of Quality and Pricing Information.*** Patients and clinicians need useful, reliable information about the quality and price of health services so they can make informed health care decisions.

STRATEGY 2: USE LIMITED HEALTH CARE DOLLARS WISELY

1. ***Eliminate Non-value Added Treatments.*** There is ample evidence that more care does not necessarily mean better care. It is estimated that a significant amount of health care spending does not result in improved outcomes.
2. ***Revamp Care for Vulnerable Populations.*** According to the Kaiser Family Foundation, historically, about half of all health care spending was used to treat just five percent of the population. Better coordinating care for our most complex, vulnerable patients—low-income children, dual eligibles, racial and ethnic minorities, and high utilizers of health care—will help bend the cost curve.
3. ***Promote Population Health.*** According to the Centers for Disease Control and Prevention, chronic diseases, such as obesity, diabetes and heart disease, are the leading cause of death and disability and account for 75 percent of the nation’s health care spending. We need to sharpen our focus on better managing the health of a community.
4. ***Modernize Federal Health Programs.*** Updating Medicare and the Federal Employee Health Benefit Program to reflect changes in demographics, life expectancy and service delivery could save an estimated \$2 trillion over the next decade.

5. *Simplify Administrative and Regulatory Processes.* Reducing the administrative complexity of health care could save \$40 billion annually. Providers need to spend more time on patients, not paperwork.
6. *Reform the Medical Liability System.* CBO and other deficit reduction committees have found that medical liability reform could save \$17 billion to \$62 billion over 10 years, depending on the policies implemented.

Implementing these 12 recommendations would make our health care system more effective and efficient. This list is not exhaustive, but it is a starting point of initiatives and activities stakeholders can take together. There are many things providers need to do, but we cannot do it alone. We need others to do their part—in many cases to help us, and in others to move aside so that we can forge ahead.

CONCLUSION:

Real improvements in health and health care—as opposed to arbitrary cuts to provider payment—have the ability to put our country on a more sustainable fiscal path. But slowing health care spending is only one part of the solution to our nation’s fiscal crisis. And, hospitals are just one component of the health care system. **Together, we need to create solutions that allow individuals to access the care they need, when and where they need it, and have it delivered in the safest, most cost-effective manner.** By focusing our efforts and taking responsibility for that which we can control, together we can ensure a healthier tomorrow.



American Hospital Association®

Ensuring a Healthier Tomorrow

*Actions to Strengthen Our Health Care System and
Our Nation's Finances*

THE PROBLEM:

The current growth rate for health care spending is a central area of focus for policymakers. A number of factors contribute to the rise in spending, including changing demographics and the aging of the baby boom generation, the growth in chronic illness, advances in medical technologies, and system inefficiencies. Achieving a sustainable level of health care spending requires reducing both the cost of individual services and the use of total services.

Our nation has both a debt and deficit problem. At the end of 2010, the Congressional Budget Office (CBO) projected, absent changes in law, that debt held by the public would rise from \$5.8 trillion in 2008 (about 40 percent of gross domestic product, or GDP) to more than \$16 trillion in 2020 (or 70 percent of GDP). This will drive up interest rates, reduce investment and harm future economic growth. According to CBO, while the deficit has been shrinking over the past few years, at the end of fiscal year 2012 the national deficit was \$1.1 trillion – the fourth-largest deficit since World War II. Spending continues to outpace revenue.

Future growth in Medicare and Medicaid represents a serious challenge. Today, Medicare covers more than 48 million people. Baby boomers are now reaching the eligible age of 65 at the rate of 10,000 a day. The program currently costs about \$560 billion annually, and over the next decade, CBO projects Medicare costs will almost double— totaling more than \$1 trillion by 2022. In 2008, the Medicare Trust Fund began to pay out more in benefits than it received in revenue; the fund is projected to become insolvent in 2024. The 2012 Medicare Trustees Report projects that the ratio of workers-to-beneficiaries will decline from four workers per beneficiary in 1965 (the start of the Medicare program) to slightly less than three workers per beneficiary in 2011, to two workers per beneficiary in 2040. And, the Urban Institute reports that the average couple will receive \$387,000 in Medicare benefits but only pay \$122,000 in Medicare taxes over their lifetime. These major demographic shifts and trends create a significant burden for future generations.

The total number of Medicaid recipients is over 62 million. According to the Centers for Medicare & Medicaid Services (CMS), between 1990 and 2010, national Medicaid spending increased from \$72 billion to more than \$400 billion annually. Federal spending alone increased from \$40 billion to an estimated \$271 billion during this timeframe. Much of this growth has

been due to increased enrollment, caused by the recent recessions and an increase in the disabled population. But this trend is projected to continue with the implementation of the *Patient Protection and Affordable Care Act (ACA)*.

While the increase in health care spending has recently slowed, costs are still projected to rise at an unsustainable rate. Families, employers and government are struggling with rising costs. Chronic illnesses—such as obesity, diabetes and heart disease—are draining the health of Americans young and old. Shortages of physicians, nurses and other caregivers are projected to grow even worse in 2014 when health coverage will be expanded to 32 million individuals. While health care quality, safety and efficiency are improving, care must be better integrated and coordinated.

THE SOLUTION:

The AHA's vision is a society of healthy communities where all individuals reach their highest potential for health. Health coverage is critical to fulfilling this vision. The ACA expanded access to health care coverage, enacted significant insurance reforms and put in place opportunities to reform the delivery system. To help expand health care coverage to millions, the hospital field will undergo changes that will stretch Medicare and Medicaid dollars further.

Additional provider payment reductions will not put us on a sustainable path for the future. Numerous studies have found—and the flawed physician sustainable growth rate confirms—that reducing provider payment rates does not result in reducing Medicare spending on services.

Policymakers need to call upon all stakeholders to make changes that will:

- **Promote and reward accountability.** We need to re-structure the system in a way that promotes and rewards accountability—to patients, their families and their communities—and ensures that all stakeholders are responsible and answerable for the quality, appropriateness and efficiency of health care provided.
- **Use limited health care dollars wisely.** We need to focus on using limited health care dollars more wisely—in ways that eliminate waste and improve quality of care for patients.

Focusing on these two interconnected strategies will improve the health care system, ensure the short- and long-term financial viability of these programs, and tackle the federal debt and deficit.

This paper identifies six **priority recommendations** to achieving each strategy. Each recommendation has a list of **suggested actions** that providers, the government, insurers and employers, and individuals can take to strengthen our health care system and our nation's finances. The task is a large one, and it will not be achieved overnight. But we cannot solve our problems in isolation. We must come together to ensure a healthier tomorrow.

STRATEGY 1

Promote and Reward Accountability

Providers, the government, insurers and employers, and individuals must become more accountable and work together to improve care and create a health care system where the patient is at the center of all health care decisions. Jointly, our focus must:

1. Accelerate Payment and Delivery System Reforms

New delivery models hold the promise to improve care, but they require new payment approaches that align incentives among physicians, nurses and other caregivers across the continuum. The AHA supports the implementation of a multi-stage, coordinated plan to adopt payment models that encourage and support delivery reform. Providers are at different levels of readiness to adopt new care models and payment approaches; it follows that such a plan would need to plot a path of evolution and allow providers to enter and move along the path based on their readiness. For example, payment approaches should support accepting accountability for care coordination and larger units of services, such as medical homes; combining hospital, physician and/or post-acute services reimbursement into one bundled payment; or forming accountable care organizations (ACOs). But for such innovations to occur and thrive, a number of legal and regulatory barriers that stand in the way of allowing hospitals, doctors and other providers to work together must be overcome. At the end of 2009, the AHA Board of Trustees approved a white paper on payment reform; for more, visit:

<http://www.aha.org/content/00-10/09-11-payment-reform-report-board-action.pdf>.

Actions by Providers:

- ✓ Actively participate in one or more new care models to develop the competencies for accountable care, such as better coordinating care and assuming greater accountability for the quality and efficiency of services.
- ✓ Participate in national and/or local delivery and payment reform demonstration projects.
- ✓ Develop partnerships with other provider or community organization to enhance care coordination.
- ✓ Explore and simplify a single patient assessment instrument across care settings to ensure appropriate transitions in care.

Actions by the Government:

- ✓ Implement a sufficient range of federal and state delivery and payment innovations to enable participation by all types of providers.
- ✓ Ensure continued funding for the Center for Medicare and Medicaid Innovation.
- ✓ Provide timely, meaningful data to providers so they can engage more easily in alternative delivery models.

- ✓ Aggressively evaluate and then expand delivery models that are successful in reducing expenditures while enhancing quality.
- ✓ Establish financial incentives for providers and patients to participate in models that move away from fee-for-service reimbursement and reward value.
- ✓ Remove barriers to clinical integration to allow doctors, hospitals and others to work together in teams or networks, especially those related to antitrust, the patient referral (“Stark”) law, civil monetary penalties, anti-kickback, and the Internal Revenue Service.
- ✓ Permit, encourage and simplify broad-scale hospital-physician “gain sharing.”
- ✓ Expand competitive bidding under the fee-for-service system to include medical devices and equipment.
- ✓ Align the Federal Employees Health Benefits Program (FEHBP) with Medicare to require plans to use alternative payment methods, such as ACO arrangements or value-based purchasing.

Actions by Insurers and Employers:

- ✓ Collaborate with providers to expand the number and type of available delivery and payment reform options.
- ✓ Offer financial incentives to providers and enrollees to participate in new models of care.
- ✓ Re-design payment methods to recognize time spent by physicians and others in coordinating patient care, especially

following a hospital or skilled nursing facility stay.

Actions by Individuals:

- ✓ Actively seek out and participate in multidisciplinary care arrangements, such as ACOs and medical homes.

2. Eliminate Preventable Infections and Complications

For many years, providers have worked diligently to improve the safety and quality of the care they provide. Through the AHA's *Hospitals in Pursuit of Excellence* (HPOE) initiative (www.hpoe.org), hospitals are sharing field-tested practices, tools, education and other resources to support efforts to meet the Institute of Medicine's six aims: care that is safe, timely, effective, efficient, equitable and patient-centered. HPOE was created to help accelerate performance improvement and support delivery system transformation.

Hospitals have made impressive strides in reducing infections and preventing complications in care. According to the Centers for Disease Control and Prevention (CDC), over the past decade, hospitals have reduced the rate of central-line associated blood stream infections (CLABSI) by 58 percent, saving \$1.8 billion in excess health care costs. More than 1,100 hospitals from 44 states, the District of Columbia and Puerto Rico were enrolled in a national effort called *On the CUSP: Stop BSI* which was led by the AHA's Health Research & Educational Trust (HRET) affiliate and supported by the Agency for Healthcare Research and Quality (AHRQ). Nearly 1,000 hospitals are participating in a national effort to reduce catheter-associated urinary tract infections (CAVTIs) led by HRET, supported by AHRQ. Also, through its Hospital Engagement Network contract with the federal government, the AHA, in partnership with 31 state hospital associations, has engaged nearly 1,600 hospitals in efforts to reduce infections, adverse drug events, injuries and preventable hospital readmissions.

Actions by Providers:

- ✓ Actively participate in national efforts to achieve reductions in CLABSIs, CAVTIs, adverse drug events and preventable hospital readmissions.
- ✓ Eliminate preventable mortality in hospitals as reflected by a reduction of the publicly reported all-cause, 30-day mortality rates for acute myocardial infarction, heart failure and pneumonia to 12.1 percent in 2013, to 11.7 percent in 2014, and to 11.2 percent in 2015.
- ✓ Report to a Patient Safety Organization to better track, understand and prevent errors.
- ✓ Contribute at least one best practice to the AHA's HPOE portfolio of resources to accelerate performance improvement.

Actions by the Government:

- ✓ Expand national governmental efforts like CMS's Partnership for Patients to support quality and safety improvement.
- ✓ Align value-based purchasing initiatives across all providers to ensure they are working toward the same goals.
- ✓ Limit provider payment penalties related to readmissions, infections and complications only to those that are truly preventable.
- ✓ Adopt meaningful measures related to care coordination, patient outcomes and efficiency across the care continuum.
- ✓ Develop quality measures that use data from all payers.
- ✓ Coordinate resources with respect to measure development and reporting.

Actions by Insurers and Employers:

- ✓ Provide data, information, tools and technologies to providers to identify opportunities to reduce infections and readmissions.
- ✓ Encourage device companies to produce and utilize software-controlled monitoring systems to help reduce medical errors and avoidable injuries.
- ✓ Offer financial incentives to eliminate CLABSI as well as other healthcare-acquired infections and complications.
- ✓ Design safety checklists (such as Blue Surgical Safety ChecklistSM) and encourage providers to adopt them.

- ✓ Develop materials and programs to help members and employees understand medication management to prevent unnecessary readmissions.

Actions by Individuals:

- ✓ Use publicly available information on quality, infections and complications to choose doctors and hospitals with lower rates.
- ✓ Ensure your doctors, nurses and care team – as well as family members and visitors – wash their hands frequently to prevent the spread of infection.
- ✓ Get recommended vaccinations.

3. Engage Individuals in their Health and Health Care

Given that unhealthy behavior, such as smoking, poor diet and sedentary lifestyles, accounts for as much as 40 percent of premature deaths in the U.S., a great opportunity to improve health and decrease costs lies in spurring patients, families and communities to take responsibility for their own health and health care. Strategies to engage patients must be identified and adopted. The AHA’s Committee on Research is examining this issue in depth and plans to release a report in early 2013. The committee is focusing on strategies for hospitals to become more “activist” in their orientation and move “upstream” to intervene earlier in disease states in order to improve outcomes and reduce health care costs. Together, we must find ways to help improve individual behaviors and develop a culture that supports patient and family engagement.

Actions by Providers:

- ✓ Place individuals, their family caregivers and their advocates at the center of all care planning decisions.
- ✓ Involve patients and families in multidisciplinary rounds.
- ✓ Establish patient and family advisory councils, and involve patients/families in hospital planning, program development and quality improvement efforts.
- ✓ Reduce health care disparities by increasing diversity in hospital staffing, leadership and governance.
- ✓ Provide easy-to-read, customized educational materials and instructions.
- ✓ Encourage shared decision-making.
- ✓ Use “teach-back” methods to ensure patient/family understanding.
- ✓ Explore the use of e-mail, social media, video conferencing and other technologies to better connect patients, families and caregivers.

Actions by the Government:

- ✓ Offer incentives to Medicare and Medicaid enrollees to engage in their care planning and self-management of chronic conditions.
- ✓ Support use of telehealth and e-visits.
- ✓ Provide a national Web-based repository for patient education materials in multiple languages that can be used by providers.
- ✓ Lead a multi-stakeholder effort to promote the development of advanced care directives.

Actions by Insurers and Employers:

- ✓ Provide patient education materials, guides and aids to members and employees.
- ✓ Explore use of web tools, social media and other technologies to provide health information to members and employees.
- ✓ Support use of telehealth, e-visits and home health care.
- ✓ Provide workplace wellness programs for employees.

- ✓ Vary health insurance cost-sharing based on enrollee/employee participation in maintaining or improving his/her health.
- ✓ Assist members and employees with their health literacy so they can better understand health information and use that information to make good decisions.

Actions by Individuals:

- ✓ Seek health information and knowledge.
- ✓ Communicate your wishes to your family and your care team often.
- ✓ Ask questions to make informed choices about your care.
- ✓ Fill and take medications as prescribed.
- ✓ Schedule and attend follow-up visits.
- ✓ Comply with treatment plans and protocols.
- ✓ Know who on the care team to contact if you have questions or need additional assistance.

4. Better Manage Advanced Illness

All individuals need to engage in advance care planning early and throughout their life cycle so their wishes about end-of-life care are understood and honored. These are difficult, emotional conversations, but they are critical if we want to better honor patients' wishes and remove barriers to expanding access to palliative care. When individuals and families are informed of their choices, they often prefer to spend their last days at home with hospice rather than in hospital intensive care units. Individuals and families must be encouraged to address these difficult decisions so that appropriate, compassionate care can be provided at the right time, in the right setting.

The AHA's Committee on Performance Improvement has spent 2012 focusing on effectively integrating advanced illness management into the care continuum. Hospitals that develop and integrate advanced illness management strategies can increase quality, improve patient satisfaction and remove inefficiencies in the health care system. Its first report, *Advanced Illness Management Strategies*, is available at: <http://www.aha.org/about/org/aim-strategies.shtml>. A second report, *Engaging the Community and a Ready, Willing and Able Workforce*, will be available at the end of 2012.

Actions by Providers:

- ✓ Expand access to advanced illness management services, by integrating palliative care and hospice service into the care continuum.
- ✓ Educate physicians, nurses and other caregivers to provide advanced illness management services.
- ✓ Make a discussion of advanced illness care part of the "Welcome to Medicare" physical examination.
- ✓ Use Physician Orders for Life-Sustaining Treatment (POLST) order sets to identify the medical treatment patients want toward the end of their lives.
- ✓ Ensure POLST order sets travel with patients during transitions in care, especially

between skilled nursing facilities and hospitals.

- ✓ Increase awareness of the benefits of advanced illness management services in the community.

Actions by the Government:

- ✓ Increase public awareness of the benefits of advanced illness management.
- ✓ Reimburse providers for discussing a patient's goals/wishes.
- ✓ Require all Medicare and adult Medicaid patients to have an advance directive.

Actions by Insurers and Employers:

- ✓ Expand coverage and reimbursement of hospice and palliative care.

- ✓ Reimburse providers for discussing a patient's goals/wishes.
- ✓ Encourage enrollees to have an advance directive.

Actions by Individuals:

- ✓ Understand the benefits of advanced illness management.
- ✓ Discuss your goals/wishes with your family, primary care physician and other caregivers early and throughout your life.
- ✓ Complete an advanced directive before advanced illness occurs.

5. Advance Health Information Technology and Electronic Health Records (EHRs)

Adoption of health information technology (IT), if done right, can improve health care quality and efficiency. However, policymakers have been impatient to see its benefits and have moved to regulate ahead of field experience and capacity in some areas. Policymakers should focus on ensuring that existing incentive programs result in widespread adoption and use of EHRs by all providers, regardless of size and location, and not in widespread penalties. Additionally, all stakeholders need to promote and invest in health information exchanges. Rational support will ensure the country realizes the full potential of IT, from standardizing orders and notes, to ensuring that needed information follows the patient, to facilitating quality improvement goals.

Actions by Providers:

- ✓ Adopt and use EHRs by 2015.
- ✓ Implement standards that support interoperability.
- ✓ Help reduce health care disparities by increasing the consistent collection and use of race, ethnicity and language preference data.
- ✓ Report quality measures through EHRs when sufficient infrastructure exists.
- ✓ Share best practices in how health IT can support care transformation.
- ✓ Adopt and promote telemedicine to extend access to care in small, rural and underserved communities.

Actions by the Government:

- ✓ Invest in field testing and necessary infrastructure to allow for accurate and feasible reporting of quality measures through EHRs.
- ✓ Establish unique patient identifiers to link individuals to their health records.
- ✓ Create a realistic national plan for adoption of interoperability standards that allow providers to share health information that includes systematic support for standards adoption.
- ✓ Invest in health information exchanges.

- ✓ Ensure privacy regulations are coordinated across programs.
- ✓ Create data-sharing mechanisms between the Medicare and Medicaid programs, health plans, providers and others.

Actions by Insurers and Employers:

- ✓ Use unique patient identifiers to link individuals to their health records.
- ✓ Use interoperability standards that allow providers to share health information.
- ✓ Enable electronic exchange of eligibility, claims, and other administrative information among payers and providers.
- ✓ Develop systems that integrate clinical and administrative functions, such as billing, prior authorization and payment.
- ✓ Provide monthly electronic "explanation of benefits" statements to consumers.
- ✓ Ensure privacy regulations are coordinated across programs.

Actions by Individuals:

- ✓ Create a personal health record to maintain a summary of one's medical and health history.
- ✓ Use other automated tools to better manage one's health.

6. Promote Transparency of Quality and Pricing Information

Individuals deserve access to information about the quality and price of their health care. Hospitals are committed to sharing information so that individuals can make informed decisions about their care. As a founding partner of the Hospital Quality Alliance, the AHA has spent nearly a decade working with other stakeholders to identify good, reliable measures that could be used to report publicly on hospital care. Currently, hospitals are reporting on more than 160 measures for the Medicare program alone. Reporting on quality measures is often linked to hospital payment, through programs such as value based purchasing, meaningful use of EHRs, readmission penalties and healthcare-acquired conditions. Hospitals also are reporting measures for state Medicaid programs, for accreditation organizations such as The Joint Commission, for employer groups such as The Leapfrog Group, and for other private insurers such as Blue Cross Blue Shield. Hospitals are committed to fulfilling reporting requirements, yet are struggling to comply with multiple and often unaligned requirements. We need a rational approach for developing meaningful measures that can satisfy the interests of providers, individuals and other stakeholders so that the information gathered is used in a meaningful manner. Additionally, information about prices, in particular, may result in individuals being more discriminating in purchasing and using health care services, if the information made available is useful.

Actions by Providers:

- ✓ Participate in state efforts to make consistent and meaningful quality and pricing information available to patients.
- ✓ Work with health plans to make real-time information available to patients on their expected coverage and out-of-pocket costs for specific services on a pre-service basis.
- ✓ Examine the hospital charge structure and mechanisms to avoid public confusion about the difference between charges, payment levels and patient out-of-pocket costs for specific health care services.

Actions by the Government:

- ✓ Require that information about insured enrollees' expected out-of-pocket costs is available to them through their insurance company or public program.
- ✓ Require all key stakeholders—hospitals, physicians, payers, pharmaceutical and medical device companies, vendors and other—to participate in the development of meaningful and understandable information on the quality and pricing of their services to help aid patient decision-making.
- ✓ Ensure that the data reported are meaningful to individuals and not overly burdensome for stakeholders to report.

- ✓ Provide pricing comparisons for all plans in state (or federal) health insurance exchange(s).
- ✓ Provide incentives, such as discounts, for those individuals who choose high-value plans or providers.

Actions by Insurers and Employers:

- ✓ Support health care coverage transparency by making premium, coverage, and cost-sharing information readily available to individuals using consistent language and formats.
- ✓ Provide out-of-pocket cost estimates to enrollees.
- ✓ Provide ready access to information on coverage of specific needed services and abide by prior authorizations.

Actions by Individuals:

- ✓ Better understand quality and pricing information so you can make informed health care decisions.
- ✓ Consider “shopping” for routine health care services based on price and quality.

STRATEGY 2

Use Limited Health Care Dollars Wisely

While increased accountability of providers, government, payers and individuals will reduce costs, as a nation we are faced with limited resources. We must create a balanced strategy to allocate limited funding and resources appropriately by ensuring that every action, transaction, test and procedure positively affects the health of the patient. Jointly, our focus must:

1. Eliminate Non-value Added Treatments

There is ample evidence that more care does not necessarily mean better care. It is estimated that a significant amount of health care spending does not result in improved outcomes. Recently, a number of physician organizations collaborated to identify commonly used, but often unnecessary, services, tests, and procedures in an initiative called “Choosing Wisely.” Examples include excessive use of antibiotics, unnecessary imaging tests, and use of surgery when watchful waiting would be better. This type of collaboration should be expanded, measured and shared as a way to educate physicians, patients and their families. Additionally, service delivery and payment reforms, such as medical homes, ACOs, bundled payments and value-based purchasing, hold promise for eliminating inefficient and unnecessary care.

To use resources more wisely, we have to know what works best. Yet often patients, providers and others don't have the best information to make informed health care decisions. That requires investment in comparative effectiveness research to develop and use evidence-based medicine. Comparative effectiveness research is an important mechanism for improving quality, decreasing unjustified variation in care, and reducing health care costs. And, when it includes the cost of innovations, it can increase the value of every dollar spent.

Actions by Providers:

- ✓ Eliminate overuse, underuse and misuse of treatments and services.
- ✓ Ensure patients, physicians and others are knowledgeable about best practices.
- ✓ Collaborate with others in the provider community to implement evidence-based recommendations in the “Choosing Wisely” campaign and/or develop similar hospital field recommendations.
- ✓ Make comparative effectiveness research available to patients, families, clinicians and others so they have the best information to make decisions.
- ✓ Increase the use of generic drugs.

Actions by the Government:

- ✓ Provide payment incentives for reducing preventable readmissions, infections and complications.
- ✓ Reward providers who follow recommended best practices.

- ✓ Allow inclusion of cost-effectiveness data in comparative effectiveness research.
- ✓ Limit the exception to the prohibition on self-referral for in-office ancillaries.
- ✓ Provide funding for pilot programs to develop new processes for care.
- ✓ Allow providers to clinically integrate so they may reduce inefficient care.

Actions by Insurers and Employers:

- ✓ Require vendors and manufacturers to provide cost data.
- ✓ Require prior-authorization of certain advanced imaging tests and procedures by providers who have a history of overuse.
- ✓ Utilize cost-effectiveness findings in payment and coverage decisions.

Actions by Individuals:

- ✓ Seek data on best practices to understand which drugs, devices and treatments may be most effective.

- ✓ Exercise restraint in demanding services your physician says are marginally or not effective.

2. Revamp Care for Vulnerable Populations

According to the Kaiser Family Foundation, historically, about half of all health care spending was used to treat just 5 percent of the population. Better coordinating care for our most complex, vulnerable patients—low-income children, dual eligibles, racial and ethnic minorities, and high health care utilizers—will lead to lower costs. Medicaid and the Children’s Health Insurance Program (CHIP) provide health insurance coverage to one-third of all children. Among children, the top 10 percent of enrollees account for 72 percent of total Medicaid/CHIP spending on children. At the same time, 30 percent of children enrolled in Medicaid/CHIP receive little or no care—in some cases despite having special health care needs or chronic conditions. To change the long-term trajectory of health care spending in America, we must focus on improving health care for our children, with a special focus on childhood obesity and high risk births.

In addition, there are more than 9 million dual eligibles enrolled in both Medicare and Medicaid. These individuals tend to be among the sickest and poorest individuals, and yet they must navigate both government programs to access necessary services. Care for this population is often fragmented, lacking management and coordination at the program level. Improving care coordination alone would result in better outcomes at lower cost. AHA’s 2011 report *Caring for Vulnerable Populations* (<http://www.aha.org/research/cor/caring/index.shtml>) highlights nine best practice recommendations for hospitals to implement to improve care for this challenging patient population.

Actions by Providers:

- ✓ Adopt person-centered care practices by placing individuals, their family caregivers, and their advocates, including non-traditional, community-based caregivers, at the center of all care planning decisions.
- ✓ Institute multidisciplinary care teams to coordinate health care and support services with primary care practitioners at the core.
- ✓ Adopt an effective care plan based on an initial comprehensive patient assessment, and periodic reassessments, to reflect evolving patient needs.
- ✓ Reduce health care disparities by increasing cultural competency training of the health care workforce.
- ✓ Collaborate with state and community programs to conduct outreach to high-risk pregnant women.
- in a timely manner to support care coordination.
- ✓ Develop and apply valid, reliable and meaningful measures of care coordination and quality outcomes specific to vulnerable populations.
- ✓ Assume under Medicare the full financial responsibility and coverage of Medicare premiums and cost sharing for the dually eligible to treat Medicare beneficiaries equally and to reduce administrative complexity.
- ✓ Promote and support Medicare and Medicaid financing mechanisms, payment arrangements and administrative and regulatory functions to encourage and support care coordination.
- ✓ Encourage and financially support care coordination across the full continuum of care.

Actions by Government:

- ✓ Create data-sharing mechanisms among the Medicare and Medicaid programs, health plans, providers and other government programs to collect, analyze and report data
- Change both Medicare and Medicaid to overcome care and coverage coordination issues and conflicting administrative requirements and financial incentives to

increase administrative efficiency in caring for the dually eligible.

- ✓ Retain essential support services that are not covered by Medicare and some Medicaid programs, such as dental and vision services and transportation to appointments, if they are shown to reduce long-term costs.
- ✓ Monitor high prescribers and users of prescription drugs in the Medicaid program.
- ✓ Require manufacturers of brand-name drugs to pay the federal government a rebate on drugs purchased by enrollees in the low-income subsidy program for the Medicare Part D benefit.

Actions by Insurers:

- ✓ Collaborate with providers and other care practitioners to ensure that administrative and financial barriers do not impede care coordination.
- ✓ Embrace new innovations in payment and care delivery.

Actions by Individuals:

- ✓ Take an active role in care management and, to the extent possible, assume personal responsibility for your health care.

3. Promote Population Health

We need to accelerate initiatives and identify more effective approaches to health promotion, primary care and disease prevention, and management of chronic disease. As a country, we need to sharpen our focus on better managing the health of a community. Today, nearly half the population suffers from at least one chronic health condition such as obesity, diabetes or asthma. Chronic disease affects not only health and quality of life, but also contributes to the rapid growth in health care utilization and spending, and other societal costs, such as sick time and disability. According to the CDC, chronic disease accounts for about 75 percent of the nation's aggregate health spending. To halt declining health, we must remodel the way primary care services are delivered and compensated and find ways to better manage chronic illness, treat complications early, minimize acute care and move towards population health. Efforts to improve population health can help reduce overall health care spending.

In January 2011, the AHA Board released a call to action for hospitals to be leaders in creating a culture of health. They encouraged hospitals to start by engaging their own employees in health and wellness activities. The report (available at: <http://www.aha.org/research/cor/creating-culture/index.shtml>) highlights current hospital activities, gives examples of promising practices and provides recommendations to the field. In addition, addressing disparities will be vital to performance excellence and improved community health. The U.S. Census Bureau has found that racial and ethnic minorities currently represent one-third of the U.S. population and will become a majority of the population in 2042. While multiple societal factors impact disparities in care, including environmental and other social determinants, the AHA and other national health care organizations have come together to create a national call to action to eliminate health care disparities. Resources, best practices and guides to eliminate disparities are available at www.equityofcare.org.

Actions by Providers:

- ✓ Serve as a role model of health for the community and create a culture of healthy living.
- ✓ Eliminate tobacco-use on the hospital campus.
- ✓ Act as a convener to link the various components of wellness and primary care in

communities to build an integrated, regional approach to health.

- ✓ Engage the community to offer health education, outreach and programs; work with schools, faith-based organizations and other community partners to provide screenings, health education, health literacy and wellness programs.

- ✓ Participate in the Partnership for a Healthier America’s “Healthy Hospital Initiative” to curb childhood obesity within a generation.
- ✓ Eliminate all trans fat from hospital cafeterias; include nutrition labeling on all products and menus.
- ✓ Implement an employee wellness program. Include a variety of program offerings, such as an employee health risk assessment, biometric screening, and health coaching. Provide positive and negative incentives to increase participating and improve outcomes.
- ✓ Review the AHA’s guide on Equity of Care to help address and eliminate disparities of care in your community.

Actions by the Government:

- ✓ Modify reimbursement structures to reward primary care.
- ✓ Permit non-physician practitioners (NPPs) to practice to the full extent of their training.
- ✓ Encourage greater personal responsibility around lifestyle behaviors.
- ✓ Ensure a strong public health infrastructure.
- ✓ Reduce barriers toward receiving high-value preventive services.
- ✓ Encourage policy changes that promote a healthier lifestyle (i.e., prohibiting tobacco use in public areas, banning trans-fats in restaurants and eliminating sugary drinks from school cafeterias) at the local level.

Actions by Insurers and Employers:

- ✓ Offer insurance products with lower premiums for patients who receive recommended preventive services or who improve their health.
- ✓ Collaborate with providers to identify opportunities and financial rewards to improve or excel in their patients’ health outcomes (i.e., controlled blood sugar).
- ✓ Educate employees on the appropriate use of preventive services and the resources offered by their medical plans.
- ✓ Implement employee workplace wellness programs.
- ✓ Explore ways to reduce access and time barriers to preventive services (such as offering periodic onsite screenings, coaching and flu shots)

Actions by Individuals:

- ✓ Adopt healthy behaviors, especially around diet, physical activity, alcohol, tobacco and drug use.
- ✓ Know and monitor your key indicators of health (i.e., blood pressure, glucose, cholesterol, body mass index).
- ✓ Engage in employer-offered wellness activities.
- ✓ See your primary care physician annually. Receive all preventive immunizations, tests and screenings.
- ✓ Learn and practice self-management of chronic conditions.

4. Modernize Federal Health Programs

The Medicare program was created nearly 50 years ago; it needs to be modernized to reflect changes in demographics, life expectancy, medical science, and technology, and how services are delivered. Today’s Medicare beneficiaries receive significantly more in benefits than what they paid through taxes during their working years to support the program. The Urban Institute reports that the average couple will receive \$387,000 in Medicare benefits but only pay \$122,000 in Medicare taxes over their lifetime. In addition, the Medicare Trustees Report projects that the ratio of workers-to-beneficiaries will decline from four workers per beneficiary in 1965 (the start of the Medicare program) to slightly less than three workers per beneficiary in 2011, to two workers per beneficiary in 2040. The current contribution structure must be modernized, and take into account beneficiary income levels.

As Congress and the Administration have debated deficit reduction, several “plans” and proposals have emerged. These have often been the result of bipartisan commissions, such as the National Commission on Fiscal Responsibility and Reform (also known as “Simpson-Bowles”) and the Debt Reduction Task Force (also known as “Rivlin-Domenici”). These various plans

identified a number of potential policy options that would curb federal spending. The AHA supports a number of these options, which could save an estimated \$2 trillion over the next decade.

Actions by the Government:

- ✓ Gradually increase the eligibility age for Medicare to age 67 with appropriate opportunities for those close to retirement age to purchase insurance coverage in an exchange.
- ✓ Create a combined annual deductible for Medicare Parts A and B.
- ✓ Add a stop-loss limit to Medicare, as is common with insurance policies in the private sector.
- ✓ Gradually increase the basic Medicare Part B premium from 25 to 35 percent of program cost.
- ✓ Modify supplemental insurance (Medigap) plans to avoid unnecessary utilization.
- ✓ Restrain growth in the cost of the FEHBP by increasing the federal government’s annual contribution based on a measure of inflation linked to the overall economy.
- ✓ Speed up the availability of generic biologics, and prohibit brand-name companies from entering into “pay-for-delay” agreements with generic companies.
- ✓ Use Medicare’s buying power to increase rebates from pharmaceutical companies.

5. Simplify Administrative and Regulatory Processes

Providers face duplicative regulations and high compliance burdens, as well as varying claims-processing and record-keeping requirements, imposed by the array of public and private insurance plans. Care can be more affordable if health care professionals spend more time at the bedside and less time on paperwork. Insurers and employers also want to reduce administrative costs. The Center for American Progress estimates that administrative costs consume 14 percent of all health care expenditures, and that at least half of this spending is wasteful. Its analysis found that reducing the administrative complexity of health care could save \$40 billion annually.

Additional cost savings could be achieved through regulatory relief, such as limiting and better coordinating the flood of new and often overlapping auditing programs that are drowning providers with duplicative audits, unmanageable medical record requests and inappropriate payment denials. No one questions the need for auditors to identify fraud or correct billing mistakes; however, the multiplicity of federal, state and private payer programs are resulting in unnecessary costs and burdens. Similarly, the many credentialing and quality improvement initiatives established by regulators, private accreditors and payers have conflicting and overlapping requirements that make care delivery more expensive.

Actions by Providers:

- ✓ Utilize standardized credentialing databases and systems.
- ✓ Engage in the Council for Affordable Quality Healthcare’s (CAQH) Committee on Operating Rules for Information Exchange (CORE), the entity designated by the Department of Health and Human Services to develop operating rules to streamline standardized transactions.
- ✓ Become certified as compliant with CORE operating rules.

Actions by the Government:

- ✓ Require in contracts with vendors that they become CORE-certified.
- ✓ Streamline and coordinate billing processes, including eligibility inquiries, claim status and remittance information.
- ✓ Adopt common operating rules to standardize provider and health plan communication.
- ✓ Simplify program integrity efforts by synchronizing the roles of auditors.

- ✓ Require auditors to improve their accuracy or face financial penalties.
- ✓ Limit the number of medical records that can be requested at one time or within any month.
- ✓ Apply predictive analytics to focus reviews and identify potential inappropriate use of services.
- ✓ Standardize provider credentialing requirements.
- ✓ Align quality measurement and reporting across all public and private payers.

Actions by Insurers and Employers:

- ✓ Overhaul administrative processes to standardize and automate five functions: claims submissions, eligibility, claims status, payment, and remittance.
- ✓ Reduce overly complex, burdensome and inefficient paperwork.
- ✓ Limit time required for provider to complete billing procedures and processes.
- ✓ Standardize network credentialing requirements.

6. Reform the Medical Liability System

Hospitals and physicians continue to face skyrocketing costs for professional liability insurance. This is affecting access to care as physicians leave states with high insurance costs or stop providing services that expose them to higher risks of lawsuits. This also often leads clinicians to practice “defensive medicine”—providing extra, often unnecessary, care to minimize the risk of lawsuits. Analysts note that liability reform could save \$17 billion to \$62 billion over the next decade.

Actions by Providers:

- ✓ Create a culture of safety where clinicians and others may report errors.
- ✓ Adhere to clinical guidelines and best practices.
- ✓ Minimize the practice of “defensive medicine.”

- ✓ Establish “safe harbor” protections for providers who follow evidence-based clinical practice guidelines.

Actions by Insurers and Employers:

- ✓ Adjust providers’ liability insurance premiums based on occurrence of preventable errors.
- ✓ Avoid overly rigid or inappropriate decisions regarding medical necessity.

Actions by the Government:

- ✓ Cap non-economic damages.
- ✓ Allow courts to limit lawyers’ contingency fees.
- ✓ Model federal proposals on proven state models of reform.
- ✓ Provide prompt compensation to injured patients based on an agreed-upon payment schedule.

Actions by Individuals:

- ✓ Resist filing unjustified malpractice claims.

Conclusion

Real improvements in health and health care—as opposed to arbitrary cuts to provider payment—have the ability to put our country on a more sustainable fiscal path. But slowing health care spending is only one part of the solution to our nation’s fiscal crisis. And, hospitals are just one component of the health care system. **Together, we need to create solutions that allow individuals to access the care they need, when and where they need it, and have it delivered in the safest, most cost-effective manner.** By focusing our efforts and taking responsibility for that which we can control, together we can ensure a healthier tomorrow.