
The American Hospital Association continues to incorporate principles that promote improved value into our ongoing policy and advocacy activities.

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

America's hospitals and health systems understand – and share – consumer's concerns, and are working hard to advance affordability by transforming the way health care is delivered in our communities. We are redesigning the delivery system, improving quality and outcomes, managing risk and exploring new payment models, and implementing operational solutions to improve patient outcomes and efficiency. But we cannot do it alone. It will take a real effort by everyone involved – insurers, drug companies, hospitals, device makers, physicians, nurses, other providers, employers and individuals. Importantly, it also will take changes in public policy.

In order to make health care more affordable, the AHA is working with Congress, the Administration, the courts and other agencies to push forward our strategic commitments toward: access, health, innovation, affordability and the individual as a partner. Below are some of our key advocacy initiatives to improve the affordability and value of health care.

Lower Drug Prices

The high cost of prescription drugs is putting a strain on Medicare, Medicaid and the entire health care system. The primary driver behind increased drug spending is higher prices, not increases in utilization. Within the health care field, "pharmaceuticals" were "the fastest growing category" in terms of pricing for every month of 2016 and for most months of 2017. And while some reports suggest that prices have moderated, we continue to see both high launch prices for new drugs and increases in prices for existing drugs. Limited competition and drug shortages have facilitated this price growth.

Hospitals and health systems are major purchasers of prescription drugs, and the high and rising cost of critical medicines is putting patient access to care at risk. Given the lack of data available on providers' experience as drug purchasers, the AHA, along with the Federation of American Hospitals and the American Society of Health System Pharmacists commissioned a study to evaluate our members' experience with drug pricing. This study was released in January and follows on a 2016 study that looked at hospital and health systems' experience with drug prices in the inpatient setting specifically. The most recent study found that after historic increases in hospital spending on drugs in the inpatient space of 38.7% per admission from 2013 to 2015, total inpatient and outpatient spending then continued to rise by an additional 18.5% per adjusted admission from 2015 to 2017. Hospitals experienced price increases in excess of 80% across certain classes of drugs, including those for anesthetics, parenteral solutions, opioid agonists and chemotherapy. Unsurprisingly, hospitals reported that increased drug spending affects many aspects of their operations. Hospitals described having to take a number of measures

to address budget pressures associated with changing drug prices, such as identifying alternative therapies, doing more in-house compounding, delaying investments in or replacement of equipment, reducing staffing and reducing services offered.¹

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

In addition, we urge Congress and the Administration to take action against anti-competitive tactics, including by denying patents for evergreened products, increasing oversight regarding “pay-for-delay” tactics and deeming them to be presumptively illegal, and limiting orphan drug incentives to true orphan drugs.

Reduce Regulatory Burden

Today’s health care system is rife with administrative burden. The hospital field faces duplicative regulation and compliance burdens, along with myriad requirements from insurance plans, each of which have different claims processing, recordkeeping and medical necessity requirements. An AHA study found that health systems, hospitals and post-acute care providers spend nearly \$39 billion a year on administrative costs – cost not associated with the delivery of patient care – to support compliance with federal regulations. This equates to nearly \$7.6 million annually for an average-sized community hospitals.²

A reduction in administrative burden will enable clinicians can spend more time on patients rather than paperwork, and enable hospitals and health systems to reinvest resources in improving care, improving health and reducing costs. The AHA has shared a set of general recommendations to reduce administrative requirements without compromising patient outcomes. These include:

- Aligning regulatory requirements within and across federal agencies and programs.
- Advancing efforts to minimize the burdens associated with prior authorization, such as lack of uniformity on requirements, transparency and regulation, along with improvements in technology and electronic transmission of information.
- Providing concise guidance and reasonable timelines to implement new rules.
- Examine the IRF “60% Rule,” which requires 60 percent of admissions to have one of 13 qualifying medical conditions.
- Permanently remove the 96-hour physician certification requirement as a condition of payment for CAHs.
- Ensuring certain laws are flexible enough to support different patient populations and communities.

Improve Access to Health Care Coverage

The AHA supports bolstering our current public/private framework for coverage. We encourage policymakers to preserve and build on the strong foundation of employer-sponsored coverage and further strengthen the individual

market while ensuring that Medicare and Medicaid are available to our most vulnerable populations. Specifically, we encourage Congress to:

- Ensure the stability and affordability of the Health Insurance Marketplaces by fully funding the cost-sharing reduction subsidies, implementing a national reinsurance program, ensuring accurate risk adjustment, and protecting consumers from health plans that do not meet all of the consumer protections established in federal law.
- Ensure patients can access all of the services necessary to get and stay healthy by protecting access to a minimum set of essential health benefits and enforcing existing federal parity laws to ensure coverage for physical and behavioral health benefits, including substance use disorder treatment.
- Encourage states to extend coverage and care to their populations through the expansion of Medicaid and private insurance. Such coverage expansions could be advanced using innovative state waivers (section 1115 and 1332 waivers) with appropriate safeguards against eligibility reductions and cost-sharing increases as well as better integration of social and health services.
- Fix the “family glitch” to ensure that working families have access to affordable coverage, and expand access to federal subsidies for middle class workers who otherwise do not have access to affordable coverage.
- Promote enrollment in all forms of coverage through a robust public relations and educational campaign. Hospitals and health systems already do considerable work to connect the uninsured to coverage, and the AHA would be an eager contributor in any public/private partnership to promote enrollment in health coverage.

Improving Price Transparency

Hospitals deal with more than 1,600 insurers. Each has different plans and multiple and often unique requirements for hospital bills. Add to that decades of government regulations, which have made a complex billing system even more complex and frustrating for everyone involved. In fact, Medicare rules and regulations alone top more than 130,000 pages, much of which is devoted to submitting bills for payment.

Hospitals and health systems are committed to improving patients’ access to information on the price of their care, and, specifically, on what the patient will pay out-of-pocket. This includes providing patients with information that is easy to access, understand and use, and explains how and why the price of patient care can vary. Price information is one of many factors, along with quality and safety, that patients should consider when making decisions about hospitals and health plans. The AHA supports increased transparency in the health care system, and many of our members are working on new ways to share cost information with patients, particularly their out-of-pocket costs. Specifically, the AHA supports:

- Providing patients with access to the information they need to make the best care decisions for themselves and their families.
- Protecting patients from surprise bills.

- o They should not be balance billed for emergency services or for out-of-network services obtained in any in-network facility when they reasonably could have assumed that the providers were in-network with their health plan.
 - o Patients should have certainty regarding their cost-sharing obligations in those situations, which are based on an in-network amount.
- Ensuring patients have access to emergency care.
 - Preserving the role of private negotiation. Hospitals and payers should be left to negotiate reimbursement for out-of-network claims without government interference.
 - Supporting state laws that work by providing a default to state laws that meet the federal minimum for consumer protections in any federal policy solution.

Support Payment and Delivery System Reforms

From 2013 to 2017, the number of hospitals that reported having established an Accountable Care Organization (ACO) increased by 102%. In 2017, hospitals participated in 297 of the 472 ACOs in the Centers for Medicare & Medicaid Services' (CMS) Medicare Shared Savings Program (MSSP), and hospital-affiliated ACOs accounted for 56% of net savings in the program.

Hospitals and health systems are testing new approaches to delivering higher-quality care at lower cost through alternative payment models. This includes the use of resources to cover health-related, non-medical services and experimenting with the use of technology in new and innovative ways. We also support promoting voluntary rather than mandatory payment and care delivery models through the Center for Medicare and Medicaid Innovation (CMMI) to advance high-value care that improves quality and efficiency. Specifically, we support:

- Balancing risk vs. reward in a way that encourages providers to take on additional risk but does not penalize those that need additional time and experience before they are able to do so.
- Providing maximum flexibility to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals. This entails waiving certain Medicare program regulations that frequently inhibit care coordination and work against participants' efforts to ensure that care is provided in the right place at the right time.
- Ensuring participants have readily available, timely access to data about their patient populations. CMMI should actively explore and dedicate resources to determining methods that would provide participants with more complete and timely data.
- Including adequate risk-adjustment methodologies to ensure that models do not inappropriately penalize participants treating the sickest, most complicated and most vulnerable patients.
- Expand access to care through the use of telehealth and other technologies by providing Medicare coverage and reimbursement for such services and including telehealth waivers in all new care models.

- Minimizing regulatory burden to the greatest extent possible, such as those related to quality reporting requirements, as discussed in our report on the regulatory burden faced by hospitals, health systems and post-acute care providers.
- Allow providers to determine how best to utilize electronic health records and other technologies while promoting exchange of health information for clinical care and patient engagement.
- Advance interoperability without increasing regulatory burden by pursuing development of a secure, efficient and useable infrastructure to connect across networks, including a common set of “rules of the road” for information sharing, widely accessible provider directories, more consistent use of standards (including application programming interfaces), better testing of health IT, and a national approach to matching patients to their records.
- Create an exception to Stark laws that is specific and dedicated to value-based payment arrangement, to provide physicians, hospitals, health systems, and other collaborators with certainty and protection they need to integrate care and achieve patient-centered outcomes in a value-based health system.

Increasing Access to Behavioral Health Care

With one in every five American adults living with a behavioral health disorder, there is widespread need for behavioral health services.³ Additionally, many people with behavioral health disorders have co-occurring physical conditions that further complicate care, negatively impact outcomes and increase overall costs. The prevalence of behavioral health issues and their interactions with – and impact on – physical health have created an increasing demand on hospitals and health systems across the continuum of care.

Increased access to behavioral health services is associated with improved health outcomes and quality as well as lower overall health costs. Research demonstrates that models that incorporate behavioral health into other medical settings through collaborative or integrated care models are associated with positive impacts on behavioral and physical health outcomes as well as reductions in use of acute services.

Hospitals’ roles in their communities as providers of emergency, inpatient and outpatient care, as well as their relationships with community-based organizations, have made them central to addressing community-wide behavioral health care needs. Hospitals and health systems are deploying a broad range of efforts to increase access to behavioral health services in the communities they serve. For example, hospitals and health systems are developing new and strengthening current community-based partnerships to prevent and address behavioral health issues outside of the four walls of a hospital or physician’s office. Many hospitals and health systems are also coordinating or integrating behavioral health assessments and services into primary care. And while emergency departments provide an always-accessible site of care for individuals with behavioral health needs, these facilities often are not well suited to provide comprehensive and ongoing care. Many hospitals and health systems are focusing on how to reduce “boarding” stays in emergency departments and connecting these patients with appropriate, timely care.

Traditional and longstanding barriers to behavioral health access – such as lack of coverage and inadequate reimbursement – remain challenges for hospitals, health systems and patients. To address these barriers, the AHA supports:

- Ensuring that all Americans have access to behavioral health coverage, and strengthening enforcement of existing federal parity laws, including substance use disorder treatment.
- Increasing reimbursement rates for providers across the behavioral health service continuum, including reimbursement for screening and monitoring of behavioral health conditions, and transitional care.
- Eliminate the barriers to coordinated, effective care posed by the restrictions under 42 CFR Part 2, which limits the ability of providers to share important information regarding care and treatment for substance use disorders.
- Increasing funding for training and development, and student loan forgiveness to support training for health professionals at all levels to reduce behavioral health workforce shortages.
- Policymakers should consider increasing funding and creating more flexible opportunities for hospitals and health systems to invest in physical space, training workforce, and adapting IT systems to better address behavioral health care needs.
- Implement policies to better integrate and coordinate behavioral health services with physical health services.

Allow Hospital Realignment

Over the last decade there have been significant changes in the health care landscape. The shift to value based payment models, coupled with numerous technological advances and new market entrants has radically altered the way in which nearly every hospital and health system delivers health care to the communities they serve.

In response to this rapidly changing landscape, hospitals and health systems are striving to become more integrated, aligned, efficient and accessible to the community. To create these coordinated systems of care, it is important to standardize the merger review process between the two federal antitrust agencies. The Federal Trade Commission has frequently used its own internal process to challenge a hospital transaction, an option not available to Department of Justice, which increases the time and expense of defending a transaction and the likelihood of an outcome that favors the agency. To help rebalance the merger review process, the AHA is urging Congress to pass the Standard Merger and Acquisition Reviews Through Equal Rules (SMARTER) Act.

The AHA also supports the removal of barriers to care transformation, such as modernizing the Anti-kickback Statute and Stark Law regulations to foster and protect arrangements that promote value-based care. The Stark Law was enacted years ago and in its current form may prohibit relationships that are designed to enhance care coordination, improve quality, and reduce waste. Every day, hospitals and health systems – and the patients they serve – experience the frustration of working to coordinate care and improve the health of their communities while continuously encountering the obstacles of existing rigid compensation regulations. The AHA supports:

- Create or adapt compensation exceptions to enable hospitals and physicians, working together, to coordinate care and improve patient outcomes.
- Remove regulatory barriers that limit hospitals ability to provide analytic tools to assist physicians in making treatment decisions for patients.

- Modify personal services and risk-sharing exceptions to protect arrangements that cover services to Medicare fee-for-service patients.
- Eliminate the regulatory requirement that a compensation arrangement not violate the federal Anti-Kickback Statute from all Stark exceptions.

Sources

1. Recent Trends in Hospital Drug Spending and Manufacturer Shortages,” NORC at the University of Chicago for the AHA, the FAH, and the ASHP, January 15, 2019.
2. “Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers,” Manatt for the American Hospital Association, October 2017.
3. National Institute of Mental Health (NIMH). (2017). Prevalence of Any Mental Illness (AMI) Among Adults. <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml>.