2016 Advocacy Agenda

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Advancing Health in America

Advocacy Agenda

Hospitals are transforming the way health care is delivered in their communities, working with other providers and community leaders to build a continuum of care to make sure every individual gets the right care at the right time in the right setting. In order to continue this transformation, and to provide patients with the access to care they need and expect, hospitals need a supportive and modernized public policy environment. In 2016, the American Hospital Association (AHA) is working with Congress, the administration, the courts, other agencies and our member organizations to:

1. **Advance health system transformation;**
2. **Protect patient access to care;**
3. **Sustain and expand gains in health coverage;**
4. **Enhance quality and patient safety; and**
5. **Promote regulatory relief.**

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1. ADVANCE HEALTH SYSTEM TRANSFORMATION

- **Medicare physician payment.** The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) created a new physician payment and performance measurement system that includes incentives for participation in advanced payment models that lead to more integrated, better coordinated care.

  AHA continues to advocate with the Centers for Medicare & Medicaid Services (CMS) on the new physician payment models and will gather additional input from hospital clinical leaders to help shape CMS's implementation of the new law. AHA also will educate members on the new payment system as implementation moves forward. Resources can be found at www.aha.org/MACRA.

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

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

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

  AHA is advocating for more consistent use of standards, better testing of health IT and more transparency about vendor products, while educating policymakers on how hospitals share information. AHA is working with a range of public and private sector partners to identify the best approach to determine national priorities for advancing interoperability and mechanisms for accountability.

- **Protecting health information (cybersecurity).** The Cybersecurity Information Sharing Act of 2015 established mechanisms and liability protections for sharing threat information among and between the public and private sectors. It also requires the Health and Human Services (HHS) Secretary to report on and create a task force to improve cybersecurity in the health care field. These are welcome developments, as the health care field is experiencing escalating attacks on its information systems by criminals seeking to disrupt connected systems and access private information.

  AHA will continue to work with the federal government to identify and disseminate best practices for protecting critical infrastructure from cyberattack and increasing information sharing. AHA also will continue in its role in educating health care leaders on the importance of cybersecurity.

- **Behavioral health.** AHA is concerned about persistent gaps in the availability of behavioral health care providers in many communities; the urgent need to address opioid addiction and its repercussions; and the need to truly establish parity in payment for mental health care.

  AHA continues to advocate to remove barriers to access to behavioral health services; promote and support field leadership to better integrated behavioral and physical health; and work to create greater public awareness and reduce stigma. AHA supports legislation to remove barriers and improve access to treatment.

- **Access to care in vulnerable communities.** The AHA Board of Trustees has commissioned a task force to confirm the characteristics of vulnerable communities and identify strategies and federal policies to help ensure access to care in these areas. The 30-member task force consists of two subcommittees that are examining the issue from the rural and urban perspectives. Its work is ongoing — it began in fall 2015 and is anticipated to conclude this fall.

  AHA continues to work with the task force to identify appropriate policies to ensure access to care in vulnerable communities and will advocate for those changes with Congress and the administration.

- **Bundling models.** CMS's Comprehensive Care for Joint Replacement (CJR) model, which bundles payment to acute care hospitals for hip and knee replacement surgery began this spring. The agency recently proposed to expand this model to include surgical treatments for hip and femur fractures other than joint replacement. At the same time, it proposed a new payment model that would bundle payment to acute care hospitals for heart attack and cardiac bypass surgery services. Under both the new cardiac and expanded CJR models, the hospital in which the initial services are provided would be held accountable for the quality and costs of care for the entire episode of care, from the date of admission through 90 days post-discharge. The cardiac model would be mandatory for hospitals in 98 geographic areas across the country, although selection of the specific areas will not be made until the final rule. The CJR expansion would apply to the 67 geographic areas already participating in that model.

AHA is supportive of CMS's pursuit of bundled payment models as programs that could help further efforts to transform care delivery through improved care coordination and financial accountability. However, the agency must, in turn, support hospitals by recognizing the significant investments of time, effort and finances that it requires to be successful under these models. At the same time, CMS is continuing and expanding its voluntary models such as accountable care organizations (ACOs) and other bundling initiatives. We are actively monitoring the CJR, cardiac and ACO models and continuously providing input to CMS on how to improve these new delivery models.

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2. PROTECT PATIENT ACCESS TO CARE

- **Site-neutral payments.** Last year's budget agreement equalizes payment rates between new, off-campus provider-based hospital outpatient departments (HOPDs) and physician offices, despite different cost structures. Some, including the Medicare Payment Advisory Commission (MedPAC), have advocated for even greater use of such "site-neutral" payments. These proposals neglect the real difference between the care provided in each setting and the patients treated.

  AHA will continue to urge Congress to both protect HOPDs under development and reject calls for any additional site-neutral payment policies. AHA supports the House-passed Helping Hospitals Improve Patient Care Act (H.R. 5273), which would revise Section 603 of the 2015 Bipartisan Budget Act to move the grandfather date for off-campus HOPDs under development from Nov. 2, 2015 to Dec. 31, 2016 or 60 days after enactment, whichever is later. We also are urging CMS to implement the existing policy in the most favorable and flexible manner possible.

- **340B Drug Pricing Program.** For nearly 25 years, the 340B program has provided help to safety-net hospitals by allowing them to stretch limited federal resources to reduce the price of outpatient pharmaceuticals for patients and expand health services. However, some want to scale it back or significantly reduce the benefits of the program. In 2015, the Health Resources and Services Administration (HRSA) proposed guidance that would reduce the volume of drugs eligible for 340B pricing. In early 2016, MedPAC recommended to Congress that Medicare payments to 340B hospitals be reduced.

  AHA will continue to urge Congress to oppose cuts to the 340B program and work with HRSA to protect patient access as it revises the rules for this program.

- **Medical education and training.** Some are advocating for significant changes and reductions in Medicare Graduate Medical Education (GME) payments to teaching hospitals. In addition, Republican leaders of the House Committee on Ways and Means introduced legislation that would reimburse indirect medical education costs through lump-sum payments rather than for each discharge, beginning with cost-reporting periods ending during or after fiscal year (FY) 2019. Furthermore, the Balanced Budget Act of 1997 imposed caps on the number of residents for which each teaching hospital is eligible to receive Medicare direct GME and indirect medical education reimbursement. These caps have remained in place and have generally been adjusted only as a result of certain limited and one-time adjustments.

  AHA is urging Congress to reject reductions in Medicare funding for indirect medical education and direct GME and pass the Resident Physician Shortage Reduction Act (S. 1148, H.R. 2124), which would increase the number of Medicare-funded residency positions.

- **Physician-owned specialty hospitals.** Some members of Congress propose significantly weakening Medicare's prohibition on physician self-referral to new physician-owned hospitals and loosening restrictions on the growth of grandfathered hospitals. The so-called Expanding Patient Access to Higher Quality Care Act (H.R. 976) and the Protecting Affordable Coverage for Employees (PACE) Act (H.R. 2513) would allow many more physician-owned hospitals to open and permit unfettered growth in existing physician-owned hospitals.

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

- **Drug prices.** Recent data show that prescription drug costs are rising rapidly — with the annual rate of increase in national spending on drugs accelerating from 2.5 percent in 2013 to 12.6 percent in 2014. Costs of specific drugs have increased even more dramatically. Even some common generic drugs have experienced dramatic price increases in recent years, leading to significant financial challenges for patients and their providers.

  AHA is evaluating options for addressing the escalation in drug prices, including bringing media and policymaker attention to the issue, requiring greater transparency on drug pricing, continuing and expanding the 340B program, allowing Medicare to negotiate prices, and engaging the presidential candidates on the issue in the 2016 campaign. However, it is critical that proposed solutions do not unfairly penalize hospitals, physicians or consumers.

- **Tax-exempt status.** According to the Internal Revenue Service, hospitals provided $62.4 billion in community benefit — or 9.67 percent of expenses — in 2011. A 2015 report from EY for AHA found that non-profit hospitals spent an average 12.3 percent of total expenses on community benefits in tax year 2012. Another study recently reported in *Health Affairs* estimates that the value of tax exemption (federal, state and local) in 2011 was $24.6 billion. Nevertheless, some policy-makers at the federal, state and local levels have questioned whether community benefits provided by non-profit hospitals are commensurate with the tax benefits of tax-exempt status.

  AHA will continue to collect information from members, including Schedule Hs, to help make the case to policymakers that hospitals provide robust community benefits that more than justify their tax exemption. And we will work with state hospital associations to combat efforts to limit tax benefits available to non-profit hospitals.

- **Medicaid provider assessments.** The Medicaid provider assessment 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 have called for limiting states' ability to use assessments as a financing tool.

AHA continues to urge Congress to reject options that limit states' ability to partially fund their Medicaid programs using provider assessments, such as recent legislation (H.R. 4725) passed by the House Energy and Commerce Committee that would reduce the maximum allowable assessment percentage from 6.0 to 5.5 percent.

- **Payments for inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs).** In recent years, IRFs have undergone multiple policy changes, including strict criteria for patients, multiple payment cuts and other policy restrictions. Collectively, these interventions have dramatically reduced overall volume and steadily increased the medical complexity of IRF patients. Today, the movement toward alternative payment models, including the implementation of mandatory bundled payments for joint replacement cases, is bringing a further round of changes to the IRF field. LTCHs also are experiencing the impact of a new payment model, the statutorily-mandated "site-neutral" policy, which began in October 2015. LTCH site-neutral rates are far lower (comparable to general acute care hospitals) and apply to patients with lower medical acuity, which account for approximately half of the LTCH patient population. In addition to these changes, post-acute care providers participating in alternative payment models still face many Medicare fee-for-service regulations that hamper innovation.

  AHA urges Congress to reject further payment cuts to IRFs and LTCHs and instead provide additional regulatory relief to those participating in episode-based models. As LTCH site-neutral payments continue to be implemented, it is important to waive regulations aligned with the prior payment structure.

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

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

- **Medicare and Medicaid DSH.** In recent years, Congress has cut Medicare and Medicaid disproportionate share hospital (DSH) payments, reasoning that hospitals would care for fewer uninsured patients as health coverage is expanded under the Affordable Care Act (ACA). However, the full promise of increased coverage under the ACA has been limited by the uncertainties in the new insurance marketplaces and some states declining to expand Medicaid in the wake of the Supreme Court's decision that the federal government could not force states to expand their Medicaid programs or risk losing all of their Medicaid funding. Thirty-two states

and the District of Columbia are expanding their Medicaid programs as of August 2016. As a result, the ACA will expand coverage to 24 million — rather than 32 million — individuals according to the most recent coverage projections from the Congressional Budget Office. AHA has been successful in delaying the Medicaid DSH cuts until 2018.

AHA continues to urge Congress to refrain from further cuts to Medicare and Medicaid DSH.

- **Medicare rural payment extensions.** Medicare rules include a number of important payment policies that ensure financial stability for hospitals that primarily treat Medicare patients, account for low patient volumes, and address the high costs of providing ambulance services in rural areas. Without legislative action, these programs will expire in 2017:

  - Medicare-dependent hospitals (MDH);
  - Enhanced low-volume adjustment; and
  - Add-on payments for ambulance services in rural areas.

  AHA urges Congress to make these important programs permanent and extend regulatory relief by passing the:

  - ***Rural Hospital Access Act (S. 332, H.R. 663), which would make the MDH program and low-volume adjustment programs permanent.***
  - ***Medicare Ambulance Access, Fraud Prevention, and Reform Act (S. 377, H.R. 745), which would make the ambulance add-on payments permanent.***

- **CAH payment policies.** Some policymakers are calling for dramatic reductions to the critical access hospital (CAH) program, including the elimination of CAH designation based on mileage between CAHs and other hospitals, and the removal of CAH "necessary provider" exemptions from the distance requirement. In addition, CMS has indicated it will enforce a 96-hour condition of payment going forward.

  AHA urges Congress to reject misguided proposals to change the CAH program. In addition, AHA supports the Critical Access Hospital Relief Act (S. 258, H.R. 169), which would remove the 96-hour piece of the physician certification requirement as a condition of payment.

- **Supervision of outpatient therapeutic services.** In the 2009 outpatient prospective payment system (PPS) final rule, CMS mandated a new policy for "direct supervision" of outpatient therapeutic services that hospitals and physicians recognized as a burdensome and unnecessary policy change. At the urging of AHA and others, CMS has since adopted several positive changes, among these, delaying enforcement of the policy through 2015 for CAHs and small and rural

PPS hospitals. Since Jan. 1, 2016, CMS has permitted its contractors to enforce the direct supervision policy in all hospitals and CAHs.

AHA continues to urge Congress to pass the Protecting Access to Rural Therapy Services (PARTS) Act (S. 257, H.R. 1611), which would protect access to outpatient therapeutic services. Additionally, AHA supports H.R. 5164 and H.R. 5613/S. 3129, which would provide immediate relief for small and rural hospitals to ensure patients continue to have access to these services.

- **Nursing education.** For more than 50 years, Title VIII has helped to build the supply and distribution of qualified nurses to meet our nation's health care needs. These programs bolster nursing education at all levels, increase the number of nurses in the workforce, and provide support for institutions that educate future nurses who are essential to ensuring the demand for nursing care is met. Nurses supported through these programs go on to provide high-quality, evidence-based practice to patients in a variety of settings including hospitals, long-term care facilities, community centers, state and local health departments, schools, workplaces and patient homes. HHS estimates that by 2020 our nation will need 2.8 million nurses – at least 1 million more than the projected supply.

  AHA in conjunction with its American Organization for Nurse Executives urges the passage of the Title VIII Nursing Workforce Reauthorization Act of 2016 (S. 3245, H.R. 2713) which would ensure that nursing workforce development programs have the current federal authorization necessary for funding in future fiscal years and proposes minor technical changes to align the programs with current roles in nursing practice.

3. SUSTAIN AND EXPAND GAINS IN HEALTH COVERAGE

- **Health plan consolidation.** As AHA had urged them to do, the Department of Justice (DOJ) in July filed suit to prevent proposed acquisitions involving four of the five major U.S. health insurance companies (Anthem's proposed acquisition of Cigna and Aetna's proposed acquisition of Humana). Similarly, at the urging of impacted state hospital associations, with the support of AHA and others, several state Departments of Insurance and 11 Attorneys General have opposed the acquisitions. The companies are, for now, planning to fight DOJ's challenge in court. If allowed to proceed, the increased market power of the consolidated companies would have harmful and far-reaching repercussions on both consumers and providers, likely increasing premiums for consumers while limiting their choice of providers and retrenching on commitments to work together with providers on innovative ways to improve access to care.

  AHA will continue to provide input to federal officials about the negative impacts that would result from these acquisitions. AHA also will support state hospital associations in impacted states with resources and technical assistance to assist in their advocacy with state officials.

- **Medicaid expansion and waivers.** The ACA led to significant increases in coverage in many parts of the country. However, the promise of coverage expansion has not been fully realized due to uncertainties in new insurance markets and the choice of some states not to expand Medicaid. States also are working with the administration to obtain waivers that allow coverage expansion and support new models of care.

  AHA will continue to support state hospital associations as they examine options for maintaining and expanding coverage and negotiating Medicaid waivers with federal officials.

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

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

- **Health Insurance Marketplaces.** 2016 is the third year of the marketplaces. While enrollment has surpassed 12.7 million, insurers continue to cite significant challenges in pricing products and managing costs due to sicker enrollees, inadequacies in the risk adjustment model, failure of the risk corridor program and incentives to price products competitively. Insurers have responded to these challenges by pursuing narrow (or "skinny") provider networks, leaving many patients with much more limited access to hospitals and health systems in their communities.

  AHA continues to advocate for robust network adequacy requirements and comprehensive, up-to-date consumer support tools, such as provider directories, to facilitate consumer access to care. We also continue to urge changes to the risk adjustment model to ensure fair payments to plans.

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4. ENHANCE QUALITY AND PATIENT SAFETY

- **Quality measurement.** Hospitals, their clinicians and the post-acute care organizations with which they work are asked to provide data on a dizzying array of quality measures. While the field is committed to quality improvement and transparency, complying with these data requests is burdensome for providers, and consumers can be confused by the volume of information. Data collection and reporting activities would be more valuable if federal agencies and others asking for data agreed on a manageable list of high-priority aspects of care on which providers would be asked to make meaningful improvement, and then to use a small and critically important set of measures to track and report on progress toward improving the care delivered and the outcomes for patients.

  AHA is working with the administration to prioritize and simplify quality reporting and improve the transition to required reporting of electronic measures. The National Academy of Medicine (formerly the Institute of Medicine) has proposed a list of high-priority topics from which this work would begin.

- **Accreditation standards and Medicare Conditions of Participation.** Well-crafted quality standards and accreditation surveys help health care delivery systems ensure they are delivering safe, effective care. The existing standards and survey processes are constantly in need of updating to keep pace with changes in the science of care. Additionally, the standards used by Medicare and accrediting bodies were developed with a siloed approach to care delivery in mind that is no longer aligned with practice in the field.

  AHA is working with the administration and accreditation bodies to modify standards so that they support integrated and coordinated care.

- **Health disparities.** Research has shown that individuals of color, of various ethnic backgrounds and with limited English proficiency have less access to care, receive different care and often have worse health than those who are white. There are many causes of the differences in health for individuals, but AHA's goal is to eliminate disparities in health by eliminating differences in access to care and differences in care delivery, and to promote better health in every community.

  AHA will continue to support the field in efforts to reduce health care disparities, including through the #123forEquity campaign to eliminate disparities.

- **Patient safety.** Hospitals and other health care organizations recognize their responsibility to ensure patients receive high-quality care during the course of their care. AHA and its member organizations have achieved important and meaningful improvements through rigorous adoption of evidence-based processes

that have been shown to prevent errors in care. But more must be done. Further, the adoption of new technologies, procedures and drugs can advance outcomes for patients, but also may result in additional challenges.

AHA will advocate continuously for the development of knowledge and adoption of practices to make care safer.

- **Adjusting outcome measures to account for socioeconomic factors.** A body of research demonstrates that readmissions are higher in communities that are economically disadvantaged. It is likely that other outcome measures, such as 30-day mortality rates and measures of efficiency, are similarly affected. MedPAC has recommended changes to the Hospital Readmissions Reduction Program to alter the calculation of payment penalties to recognize that sociodemographic factors affect the likelihood that a patient will be readmitted.

  AHA urges Congress to pass the Establishing Beneficiary Equity in the Hospital Readmission Program Act (S. 688, H.R. 1343), which would address the need for a sociodemographic adjustment. In addition, AHA supports the House-passed Helping Hospitals Improve Patient Care Act (H.R. 5273), which includes similar language to H.R. 1343 to address a sociodemographic adjustment. AHA also will evaluate the need to similarly adjust other outcome measures. AHA will press the administration to appropriately adjust outcome measures for sociodemographic factors.

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

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

5. PROMOTE REGULATORY RELIEF

- **Recovery audit contractors (RACs).** In 2015, CMS announced several changes intended to reduce the significant burden hospitals bear as a result of RAC audits. For example, Quality Improvement Organizations, rather than RACs, will bear primary responsibility for auditing the appropriateness of inpatient admissions under the two-midnight inpatient admissions criteria. In addition, hospitals with a low error rate may see a reduction in audits. Despite these incremental improvements, more reform is needed to address the contingency fee payment structure that continues to reward RACs for inappropriate denials.

  AHA urges Congress to pass the Medicare Audit Improvement Act (H.R. 2156), which would, among other measures, eliminate the RAC contingency fee structure and instead direct CMS to pay RACs a flat fee, as every other Medicare contractor is paid. It also would rationalize payments to RACs by lowering payments for poor RAC performance due to high rates of incorrect denials.

- **Two-midnight 0.2% withhold.** CMS in the FY 2017 final inpatient PPS rule reversed the unlawful 0.2% payment reduction for inpatient services that it implemented as part of the agency's original 'two-midnight' policy. A federal court last October rejected CMS's arguments that it met all of the procedural legal requirements for rulemaking when it imposed the cut and ordered the agency to publish additional justification and to allow further opportunity for hospital comments. That court order was issued in a consolidated federal case that includes a lawsuit brought by AHA, four hospital associations and four hospital organizations.

  The success of our court challenge of CMS's action means that there will be a restoration of resources that hospitals are lawfully due because CMS will make two specific adjustments to reverse the effects of the 0.2% cut: a permanent adjustment of approximately 0.2% to remove the cut prospectively for FYs 2017 and onward, as well as a temporary adjustment of 0.6% to address the retroactive impacts of this cut for FYs 2014, 2015 and 2016.

- **EHR Incentive Program.** America's hospitals are strongly committed to the adoption of EHRs and the transition to an EHR-enabled health system is well underway. CMS recently finalized rules making some needed changes to the program to increase flexibility in the short term. Unfortunately, at the same time, it also finalized rules raising the bar on meaningful use requirements yet again with Stage 3 requirements that are required in 2018. These rules contain provisions that are challenging, if not impossible, to meet and require use of immature technology standards.

  AHA continues to urge CMS to modify the Stage 3 rules to be more flexible and feasible. CMS also should delay implementation to no sooner than 2019. AHA will continue to urge Congress to monitor CMS action and step in, where appropriate.

AHA supports the Electronic Health Record Regulatory Relief Act (S. 3173), which would make changes to the federal requirements of meaningful use for the Medicare and Medicaid EHR Incentive Programs.

- **Hospital realignment.** Hospitals are reshaping the health care landscape by striving to become even more integrated, aligned, efficient and accessible to the community. To support these changes, it is important to standardize the merger review process between the two federal antitrust agencies. The Federal Trade Commission (FTC) has frequently used its own internal administrative process to challenge a hospital transaction, an option not available to the DOJ, which increases the time and expense of defending a transaction and the likelihood of an outcome that favors the agency.

  AHA urges the Senate to pass the Standard Merger and Acquisition Reviews Through Equal Rules (SMARTER) Act (S. 2102), already passed by the House, which would help rebalance the merger review process.

- **ICD-10.** The new ICD-10 coding system was implemented on Oct. 1, 2015. CMS likely will analyze claims data with the new codes for possible recalibration and refinement of payments and may propose payment cuts to offset increases CMS deems to be the result of the move to a new coding system. AHA is monitoring CMS rules to ensure proper handling of the transition to new ICD-10 codes.

  AHA will continue to educate and inform members about the importance of proper documentation and ICD-10 code assignment.

- **Administrative simplification.** By law, health care providers, health plans and clearinghouses use specific transaction standards in the course of billing and paying for health care services (HIPAA transactions). HHS likely will introduce new versions of these standards in 2016.

  AHA will safeguard against excessive burden in reporting requirements and will continue to inform members about changes in HIPAA standards and help them prepare for a successful transition.

- **Fraud and abuse barriers to care transformation.** The health care landscape is rapidly changing, driven by advances in technology, a rise in consumerism and the continued switch from payment models dictated by volume to ones focused on value. Hospitals across the nation are adapting by eliminating silos and replacing them with a continuum of care to improve the quality of care delivered, the health of their communities and overall affordability. Standing in the way of their success is an outdated regulatory system predicated on enforcing laws no longer compatible with the new realities of health care delivery. Chief among these outdated barriers are portions of the Anti-kickback Statute, the Ethics in Patient Referral Act (also known as the "Stark Law") and certain civil monetary penalties (CMPs).

  AHA is urging Congress to modify the Stark Law and the anti-kickback statute to facilitate financial relationships designed to foster collaboration in the delivery

of health care, as well as incentivize and reward efficiencies and improvements in care. AHA recently sent Congress a report, "Legal (Fraud and Abuse) Barriers to Care Transformation and How to Address Them," which outlines seven major barriers and how they impede care.

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