

Please Provide Responses to the Fields Below Electronically to be Accepted

Medicare Red Tape Relief Project

Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

Date: August 2, 2017

Name of Submitting Organization: Healthcare Financial Management Association

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Statutory__X_ Regulatory_X__

Please describe the submitting organization's interaction with the Medicare program:

HFMA is the nation's leading membership organization for more than 40,000 healthcare financial management professionals. As an organization, we are committed to helping our members improve the management of and compliance with the numerous rules and regulations that govern the industry. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant. In these roles our members interact with the disparate Medicare payment systems and related value-based payment programs. As a result, of this interaction they have experienced first hand how many of the program's outdated or misguided regulations (or statutory requirements) increase the total cost of care and decrease patient and caregiver satisfaction without commiserate improvements in quality or patient outcomes.

Please use the below template as an example of a submission regarding statutory or regulatory concerns, and submit any further concerns past those listed below in a separate Microsoft Word document in the same format. Submissions must be in the requested format or they will not be considered.

In the case of listed Appendices, please attach as PDF files at the end of the submission, clearly marked as "Appendix [insert label]"

In the case of a multitude of submissions, it is recommended that they be submitted in order of priority for the submitting organization or individual.

1. Short Description: *Make Medicare Cost-Sharing Amounts Explicitly Available with Charge and Payment Data:*

Summary: Annually, CMS makes hospital and physician charge data available to the public for common services. While cost sharing data is included in the total payment amount, the information necessary for an average Medicare beneficiary to understand their cost sharing isn't readily apparent. For example in the outpatient hospital services file, cost sharing data is included in the average total payments. For inpatient hospital services, there are two columns – one that provides “average total payments,” which includes cost sharing, and a column “average Medicare payments” that details the average amount Medicare pays a hospital. In theory a Medicare beneficiary could calculate their outpatient or inpatient cost sharing using this data. However, the information necessary to do so requires a level of sophistication far beyond what is possessed by the average Medicare beneficiary.

Proposed Solution: HFMA believes that Congress should expand on Section 4011 of the 21st Century Cures Act (Pub. L. 114–255), and pass legislation instructing CMS (and its administrative contractors) to make costing share information for specific services available to Medicare beneficiaries for services provided in settings other than hospital outpatient departments and ambulatory surgical centers. For CMS, we believe this information should be available on the hospital compare website so that a beneficiary can evaluate both cost and quality to make a truly informed decision. This is in line with recommendations from HFMA's “Price Transparency in Health Care²¹” whitepaper which suggested consensus best practices for providers and purchasers. One of those purchasers was Medicare and Medicaid.

2. Short Description: *Reform the Medicare Recovery Audit Contractor Program to Hold Contractors Accountable*

Summary: Medicare Recovery Audit Contractors (RACs) are paid a contingency fee that financially rewards them for denying payments to hospitals, even when their denials are found to be in error. We believe that CMS's two rounds of settlements with hospitals for cases inappropriately denied by the RAC is more than sufficient proof of the program's substantial flaws. In the 2014 settlement, over 2,000 hospitals settled approximately 350,000 disputed claims for \$1.47 billion. Despite the sheer size of the settlement, it did not make a dent in the administrative backlog due to inappropriately denied claims necessitating another settlement.

Proposed Solution: HFMA urges Congress to amend the statutes relating to the RAC program to incorporate a financial penalty for poor performance by RACs, as measured by Administrative Law Judge appeal overturn rates.

3. Short Description: *Provide More Regulatory Flexibility for Participants in Alternative Payment Models*

Summary: CMS’s continued application of fee-for-service (FFS) regulatory barriers within payment reform models often hinders providers’ ability to identify and place beneficiaries in the most clinically appropriate setting. It also inhibits their ability to test new, more patient-centered and streamlined clinical pathways. Testing new approaches in an environment free from artificial barriers to care coordination, such as the IRF 60 Percent Rule and the home health homebound rule, will more effectively advance solutions that improve clinical outcomes and reduce overall costs and variation.

Proposed Solution: HFMA encourages Congress to modify existing Medicare fraud and abuse statutes to create safe harbors from laws such as “Stark,” “Anti-Kickback” and “Civil Monetary Penalty for physicians, hospitals, post-acute care providers, and other entities caring for Medicare beneficiaries that participate in alternative payment models such as the Medicare Shared Savings Program or Comprehensive Care for Joint Replacement program.

4. Short Description: *Create Stark Exemptions for Clinical Integration Arrangements*

Summary: Hospitals cannot succeed in their efforts to coordinate care and participate in new payment models because of outdated statutes, such as the Anti-Kickback and the “Stark” laws.

Proposed Solution: A new exception should be created that protects any arrangement that meets the terms of the newly created Anti-Kickback safe harbor for clinical integration arrangements.

5. Short Description: *Create Safe Harbor in Anti-Kickback Statute for Assistance to Patients*

Summary: This type of safe harbor is necessary so that hospitals can help patients realize the benefits of their discharge plan and maintain themselves in the community. Arrangements protected under the safe harbor also would be protected from financial penalties under the Civil Monetary Penalties (CMPs) for providing an inducement to a patient.

Proposed Solution: The safe harbor should do all of the following:

- a. Protect encouraging, supporting, or helping patients to access care or make access more convenient
- b. Permit support that is financial (such as transportation vouchers) or in-kind (such as scales or meal preparation)
- c. Recognize that access to care goes beyond medical or clinical care, and include the range of support important to maintaining health such as social services, counseling, or meal preparation
- d. Remove the regulatory prohibition on a hospital offering advice to a patient on the selection of a provider for post-hospital care or suggesting a specific facility

6. Short Description: *Remove HIPAA Barriers to Integrated Care*

Summary: HIPAA regulations currently restricts the sharing of a patient’s medical information for “health care operations” like quality assessment and improvement, including outcomes

evaluation, or activities that relate to the evaluation of provider qualifications, competence, or performance, to information about those patients with whom both the disclosing and receiving providers have – or have had – a patient relationship. The challenge that strict regulatory prohibition poses in the integrated care setting is that frequently patients do not have a relationship with all of the providers among whom information should be coordinated. A clinically integrated setting and each of its participating providers must focus on and be accountable for all patients. Moreover, achieving the meaningful quality and efficiency improvements that a clinically integrated setting promises requires that all participating providers be able to share and conduct population-based data analyses.

Proposed Solution: The HIPAA medical privacy regulation enforced by the Office for Civil Rights should permit a patient’s medical information to be used by and shared with all participating providers in an integrated care setting without requiring that individual patients have a direct relationship with all of the organizations and providers that technically “use” and have access to the data.

7. Short Description: *Allow Treating Providers Access to Their Patient’s Substance Use Disorder Records*

Summary: Requiring individual patient consent for access to addiction records from federally funded substance use treatment programs, as current requirements do, is an obstacle to an integrated approach to patient care. It also may unknowingly endanger a person’s recovery and his or her life.

Proposed Solution: Congress should fully align requirements for sharing patients’ substance use records with the requirements in the HIPAA statute that allow the use and disclosure of patient information for treatment, payment, and healthcare operations. Doing so would improve patient care by ensuring that providers and organizations who have a direct treatment relationship with a patient have access to his or her complete medical record.

8. Short Description: *Expand Coverage for Telehealth*

Summary: Hospitals are embracing the use of telehealth technologies because they offer benefits such as virtual consultations with distant specialists, the ability to perform high-tech monitoring without requiring patients to leave their homes, and less expensive and more convenient care options for patients. However, coverage and payment for telehealth services remain major obstacles for providers seeking to improve patient care. Medicare, in particular, lags far behind other payers due to its restrictive statutes and regulations. For example, CMS approves new telehealth services on a case-by-case basis, with the result that Medicare pays for only a small percentage of services when they are delivered via telehealth.

Proposed Solution: HFMA urges Congress to expand Medicare coverage, such as by a presumption that Medicare-covered services also are covered when delivered via telehealth unless CMS determines on a case-by-case basis that such coverage is inappropriate.

9. **Short Description:** *Cancel “Stage 3” of Meaningful Use*

Summary: Hospitals and physicians face extensive, burdensome, and unnecessary “meaningful use” regulations from CMS that require significant reporting on the use of electronic health records (EHRs) with no clear benefit to patient care. These excessive requirements are set to become even more onerous when Stage 3 begins in 2018. They also will raise costs by forcing hospitals and physicians to spend large sums upgrading their EHRs solely for the purpose of meeting regulatory requirements.

Proposed Solution: HFMA’s members urge Congress to pass legislation canceling Stage 3 of meaningful use by removing the 2018 start date from the current regulations. The Administration also should institute a 90-day reporting period in every future year of the program, and gather input from stakeholders on ways to further reduce the burden of the meaningful use program from current requirements.