Medicare Red Tape Relief Project

Wisconsin Hospital Association Submission to
U.S. House Committee on Ways and Means
Subcommittee on Health
August 24, 2017

Submission #1

Short Description:
Medicare Payment to HOPDs, Section 603 of BiBA 2015

Summary:
Within the span of a week, Section 603 of the Bipartisan Budget Act of 2015 was enacted. It included a significant policy/payment change for new off-campus provider-based hospital outpatients departments (HOPDs). These impacted HOPDs were prohibited from using an entire Medicare reimbursement system, the Outpatient Prospective Payment System (OPPS). The new law caught up many projects "mid-build," including multiple in Wisconsin. Further, corrective legislation for projects caught "mid-build" provided some relief but not all projects in motion qualified. Section 603 continues to have ongoing negative impacts. CMS created additional obstacles in its implementation guidance and is now proposing in the FY 2018 OPPS rule to cut reimbursements by 50 percent more. CMS does not base this recent proposed reduction on appropriate data or analysis nor would the proposed rate be sufficient to offset actual costs of many services.

In general, the main concerns with the Section 603 law and its implementation remain: it negatively impacts the ability to locate services where care is most needed (ie: this is an access problem); it inappropriately restricts hospitals' ability to use an entire Medicare reimbursement system, the OPPS, and fails to understand the complexity of this reimbursement system. (For example, certain services that bill under the OPPS, like partial hospitalizations for mental health, have no like reimbursement under Medicare PFS); it works contrary to creating patient-centered, streamlined care delivery systems; and it is a step backwards from where healthcare should be going by creating inefficiencies in the delivery and operations of health care.

Related Statute/Regulation:
Section 603, BiBA 2015/Public Law 114-74
Final FY 2017 Outpatient Prospective Payment System Rule
Proposed FY 2018 Physician Fee Schedule Rule

Proposed Solution:
Key areas that must be corrected are: providing additional flexibility to grandfather certain "mid-build" HOPDs; exempt Partial Hospitalization Programs (PHPs) from the original Section 603 payment prohibition; and provide more flexibility to relocate existing, grandfathered HOPDs. The proposed payment cuts under the FY 2018 OPPS rule should not be finalized.

With respect to PHPs, exemption language would read: "The term 'applicable items and services' means items and services other than Partial Hospitalization Services as defined by Section 1861(ff) of the Social Security Act, Intensive Outpatient Psychiatric Services (identified, as of January 1, 2015, as Revenue codes 0905 or a 0906) and emergency department services (identified, as of January 1, 2015, by HCPCS codes 99281- 99285 (and as subsequently modified by the Secretary)). All of these proposed solutions can be done through CMS regulations, legislation or a combination of the two.

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Submission #2

Short Description:
Quality Reporting and Penalty Programs

Summary:
Hospitals are required to collect and report over 80 measures of hospital quality. Many of these measures have complicated definitions, some of which are not aligned to current best practices for care of the patients being measured. The complexity of the measures requires highly skilled clinical staff, such as registered nurses, for the data collection. Collection is time consuming and requires resources that could be better spent on patient care activities. For example, the current sepsis measure requires collection of 83 data elements, which takes on average one hour to collect per patient. In addition to the staff resources to collect the measure data, hospitals must have a contract with an approved data vendor for submitting/managing the data. An annual contract for a data vendor can range from $50,000-$100,000/year for a mid-sized hospital.

These required measures are being used in multiple and unaligned ways for payment incentive and penalty programs; Value Based Purchasing, Readmission Penalties and Hospital Acquired Condition Penalties. Two of the programs use the same measures to penalize hospitals. These programs are often in conflict with the numerous programs commercial payers are using. The cacophony of payment incentive programs is frustrating, difficult to understand and makes it hard for hospitals to prioritize their improvement efforts. There has been little evidence these programs are making a difference in improving quality and reducing costs.

CMS is also requiring hospitals to submit many of the same measures, via their electronic health record. The specifications for the electronic measures are flawed and hospitals have proven they do not reflect the care being given. In order to meet the flawed specifications, clinicians are now being forced to document care in a way that meets the specification, versus documenting clinically relevant information. The other flaw with this requirement is the hospitals are subject to the willingness and ability of their electronic health record vendors to help meet the requirements. Since the vendors are not legally bound by the requirement, they either are moving too slowly or are charging high fees to get this work done.

Related Statute/Regulation:
- Hospital Inpatient Quality Reporting Program;
- Hospital Outpatient Quality Reporting Program

Proposed Solution:
- Reduce the number of quality measures for which hospitals are accountable.
- Eliminate the payment penalty programs linked to quality measures.
- If electronic measures continue to be required, the work should start over with new measures rather than trying to create an electronic version of a measure that used to be collected manually. This would ensure measures are designed around data elements that commonly exist and reduce the burden on busy clinicians to document things that are not important to the care of the patient.
- If electronic measures continue to be required, there should be some form of influence on the electronic health record vendors to develop the capability, at an affordable price.

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Submission #3

Short Description:

Remove Geographic Restrictions on Access to Telehealth Services for Medicare Beneficiaries

Summary:

The use of telehealth technologies have been increasingly embraced by providers, patients, and payers as a means to reduce distance based barriers to access to care and to overall improve patient health.

However, Medicare beneficiaries are currently eligible for telehealth services only if the patient's location at the time services are received via telehealth (the "originating site") is located in:

- A county outside of a Metropolitan Statistical Area (MSA), or
- A rural Health Professional Shortage Area (HPSA) located in a rural census tract.

The blanket geographic restriction on access to telemedicine services in the Medicare program not only limits access to care for Medicare recipients in the excluded geographies, but indirectly also reduces access to telemedicine services in the permitted geographies. By reducing the population base that could be served by reimbursable telemedicine services, it is more difficult to achieve economies of scale necessary to justify provider telemedicine investments in just the allowable geographies.

Unlike the Medicare program, Medicaid in Wisconsin and the vast majority of other states do not have geographic restrictions on covered telemedicine services, and the trend has been for state Medicaid programs to remove such restrictions. In Wisconsin's experience, increasing access to telehealth has been seen as a cost efficient means to increase access to care and to reduce the total cost of care.

Related Statute/Regulation:

42 USC 1395m(m)(4)(c)(i)

Proposed Solution:

To remove barriers to Medicare beneficiaries' access to telehealth services in both urban and rural areas, Congress should remove blanket geographic restrictions on Medicare reimbursable access telehealth services.

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Submission #4

Short Description:

Address CMS regulation related to "direct supervision" requirements on outpatient therapeutic services.

Summary:

CMS regulations state that the physician supervision requirement inherent in "incident- to" billing for hospital outpatient department services would be generally assumed to be met where the services were performed "on hospital premises." Beginning in 2009, Centers for Medicare & Medicaid Services (CMS) introduced the concept of "direct supervision" by physicians with some commentary in Open Door Forums that the physician must be "physically present" and "immediately available" in the outpatient therapy department for initiation of outpatient therapeutic services. This requirement, which was stated as a "clarification," was a fairly drastic change in policy. CMS provided no clinical rationale for this change and acknowledged it was issued without allegations or evidence that quality of care or patient safety had been compromised in hospital outpatient departments. Further, CMS characterized the change as a "restatement and clarification" of existing policy in place since 2001.

Related Statute/Regulation:

Medicare Benefit Policy Manual

Proposed Solution:

Congress has enacted multiple enforcement moratoriums on this CMS policy due to the hardship it causes, particularly to rural hospitals. The most recent moratorium is now expired. Either CMS should pull this regulation back fully or Congress should pass a permanent extension of the moratorium.

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Wisconsin Hospital Association Submission to
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Submission #5

Short Description:

Address "96 Hour" rule for Critical Access Hospitals.

Summary:

This issue came to light in sub-regulatory guidance stemming from CMS's two midnights policy in the FY 2014 Prospective Payment System final rule. In that guidance, CMS stated that, as a *condition of payment*, physicians at Critical Access Hospitals must certify that a beneficiary may reasonably be expected to be discharged or transferred within 96 hours after admission to the CAH. If a physician cannot certify the reasonable expectation that a Medicare beneficiary will be discharged or transferred within 96 hours, then Medicare Part A payment is inappropriate.

While CMS had failed to raise this issue for well over a decade, CMS was pointing to two different and conflicting Critical Access Hospital statutes – one for Conditions of Participation (annual average of 96 hours/patient) and one for Conditions of Payment (96 hours/patient). The two differing 96 hour rules seem to stem from the 1999 Balanced Budget Refinement Act (BBRA), which made important improvements to the CAH program, including establishing the 96 hour *annual average* for participation in the Medicare program. However, the BBRA did not appear to appropriately cross-reference the corollary payment statute as well. This inadvertent failure to cross-reference the corollary statute should be corrected in order to reflect the original intent of the BBRA law.

Related Statute/Regulation:

- Conditions of Participation – a 96 hour per patient *annual average* (See: 42 USC 1395i-4)
- Conditions of Payment – barring unforeseen circumstances, 96 hour per patient for payment purposes (See: 42 USC 1395f)(a)(8))

Proposed Solution:

Conform conditions of *payment* to condition of *participation* so that both are consistent with CAHs providing care to patients on an annual average of 96 hours/patient.

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Wisconsin Hospital Association Submission to U.S. House Committee on Ways and Means Subcommittee on Health

August 24, 2017

Submission #6

Short Description:
Medicare EHR Incentive Program

Summary:

Under the Medicare EHR Incentive Program, hospitals that fail to meaningfully use certified EHR technology are subject to significant Medicare reimbursement penalties. CMS regulations have made successful avoidance of Medicare penalties unnecessarily difficult, and many of the "meaningful use" reporting requirements entail investments and workflow disruptions that outweigh potential health care cost savings or improvements in outcomes.

Many of CMS's meaningful use reporting requirements are not experience-based and have not been shown to positively affect clinical outcomes, and they are scheduled to become even more burdensome when Stage 3 begins in 2018. Many of these reporting requirements do not have widespread acceptance, are new, and with respect to the patient engagement measures, put success largely outside of the hospital's control by making it contingent on the actions of patients. In its 2017 OPPS final rule, CMS seemed to acknowledge this reality by reducing the required performance thresholds for a wide variety of Stage 3 measures in 2017 and 2018.

Further, CMS takes an "all-or-nothing" approach to Medicare EHR Incentive Program compliance, subjecting hospitals to significant Medicare penalties for failing to meet a single measure by even a single percentage point. Such an approach is punitive and does not accomplish Congress's goal of rewarding and incentivizing the delivery of high-value health care, since the hospital that meets all but one meaningful use measure would be subject to the same reimbursement penalties as the hospital that does not meet any measures.

Related Statute/Regulation:

Health Information Technology for Economic and Clinical Health ("HITECH") Act, Pub. L. No. 111–5, and accompanying regulations.

Proposed Solution:

WHA recommends that Congress consider delaying or canceling altogether Stage 3 of the Medicare EHR Incentive Program. At the very least, Congress should consider indefinitely extending for future years the Stage 3 flexibilities finalized by CMS in the 2017 OPPS rule.
WHA recommends that Congress consider establishing a 90-day reporting period for every year of the Medicare EHR Incentive Program.

WHA recommends that Congress move the Medicare EHR Incentive Program away from the punitive "all or nothing" approach and toward an approach that more equitably recognizes meaningful use achievement.

Submission #7

Short Description:

Create consistency in the federal hospital regulations regarding the use of Advance Practice Nurse Prescribers and other advance practice clinicians in a hospital setting.

Summary:

The scope of practice and use of advance practice nurse prescribers (APNPs) and other non-physician advance practice clinicians (APCs) has expanded in Wisconsin and throughout the nation over the past two decades as a means to provide more accessible and more efficient high quality care. In many cases, acts by APNPs and APCs have the same legal validity and authority as an act by a physician under state law.

However technical aspects of federal Medicare regulations have been inconsistent in their treatment of APNP and APC care in hospital settings. These inconsistencies create a highly complex and unnecessary compliance burden for hospitals as they navigate what APCs can and cannot in a hospital setting.

On the one hand, recent revisions to the CMS Conditions of Participation for Hospitals permit non-physician providers such as APNPs to be a part of the hospital medical staff and have privileges as consistent with state scope of practice laws. However, other CMS regulations governing hospitals have not similarly been consistently updated to recognize the role of APNPs and APCs, and in some cases are inconsistent based on whether the patient in a critical access hospital or a PPS hospital.

For example, while care for a patient in a critical access hospital may be "under the direction" of an APC, other critical access hospital regulations require that a "physician" certify that a patient may reasonable be expected to be discharged or transferred to a hospital within 96 hours after admission, and a "physician" must certify the need for a patient's extended stay of 20 inpatient days or more. Another example of inconsistencies in the regulations pertains to histories and physical examinations. Under critical access hospital regulations, a history and physical exam performed by an advance practice clinician must be cosigned by a physician, while in PPS hospitals, a history and physical exam performed by an advance practice clinician does not need to be cosigned by a physician.

Related Statute/Regulation:

42 CFR Part 482; 42 CFR Part 424

Proposed Solution:

Current and future CMS regulations governing hospitals and hospital payment should be revised to recognize that many traditionally "physician" roles are now performed by APNPs and other APCs in accordance with state scope of practice laws. Providing such clarity will reduce the regulatory complexity of utilizing APCs in hospital settings in accordance with the APCs scope of practice.

Submission #8

Short Description:

Address "3-day stay" requirement for admission to a nursing home after a hospital stay.

Summary:

There is a statutory requirement that a patient spend at least three consecutive days in a hospital as an inpatient in order to qualify for Medicare coverage of a subsequent stay in a skilled nursing facility (SNF). Hospital stays that are classified as observation do not count toward the three day stay requirement. Also, patients are increasingly experiencing shorter inpatient hospital stays. The PPS short-stay hospital average length of stay decreased significantly from 9.0 days in 1990 to 5.0 days in 2014, a decrease of 44 percent.

Both the use of observation stays and the shorter length of inpatient stays may sometimes result in lack of eligibility for Medicare Part A coverage for a subsequent stay in a skilled nursing facility because of the 3-day stay requirement. This 3-day stay requirement is outdated and reflects a time when inpatient stays were much longer. This is increasingly not the case in health care delivery today and this statute should be updated.

Related Statute/Regulation:

42 USC §1395x(i): Post-hospital extended care services

Proposed Solution:

- Count all time (inpatient and observation) in the hospital for purposes of determining Medicare coverage of SNF care.
- Reduce the number of inpatient days required for a subsequent admission to a SNF that is eligible for Medicare Part A coverage, to reflect increasingly shorter average lengths of inpatient hospital stays.

Submission #9

Short Description:

Revise the requirements for skilled nursing facilities (SNFs) to become training sites for certified nursing assistants (CNAs).

Summary:

The training of nurse aides must be performed by or under the general supervision of a registered professional nurse who possesses a minimum of 2 years of nursing experience, at least 1 year of which must be in the provision of long-term care facility services.

In some cases, where a SNF is affiliated with a hospital, the SNF may be able to take advantage of nursing talent in the hospital to supervise nurse aide training at the SNF which otherwise meets CMS requirements as a training site. If the requirement for 1 year of experience in a long-term care facility were made more flexible, this could expand the availability of CNA training programs. This, in turn, may increase the supply of CNAs.

From a hospital perspective, addressing the CNA workforce shortage would create better access to post-acute care services for discharged hospital patients, since SNFs are a major site for post-acute care services.

Related Statute/Regulation:

42 CFR §§483.152(a)(5)(i) and 483.152(a)(5)(ii).

Proposed Solution:

Remove the requirement that a supervising nurse of a CNA training program must have at least 1 year providing long-term care facility services.