

**Testimony  
of the  
American Hospital Association  
before the  
Committee on Small Business  
of the  
U.S. House of Representatives**

**“Improving the Paperwork Reduction Act for Small Businesses”  
February 28, 2008**

Good morning, Madame Chairwoman. I am Linda Brady, M.D., president and CEO of Kingsbrook Jewish Medical Center (Kingsbrook) in Brooklyn, NY. Kingsbrook is a medical training institution, comprised of an acute-care hospital and an adult and pediatric skilled nursing long-term care facility. In addition to our celebrated Kingsbrook Rehabilitation Institute, our centers of excellence include Brooklyn's only New York State-licensed traumatic brain injury and coma recovery unit, and a geriatric inpatient psychiatry service, a premiere program serving the mentally challenged elderly throughout the borough. On behalf of my organization and the nearly 5,000 hospitals, health systems and other health care organizations served by the American Hospital Association (AHA), and its 37,000 individual members, I appreciate the opportunity to share with you and your colleagues the administrative burdens faced by hospitals and what should be done to reduce them.

As a valued and trusted public resource, our society holds hospitals in special regard. As a result, hospitals are closely monitored and evaluated by local, state and federal, as well as private regulators who are charged with protecting the public and, in some cases, ensuring that public funds are spent wisely and in the public's best interest.

But those who provide care – hospitals, physicians, nurses and others – are increasingly concerned that health care regulation is out of control and has lost a sense of fairness and common sense. These providers know first-hand that many of today's health care regulations are too complex and inefficient, yet new ones are imposed on the system every day. Health care workers strive to keep up with these regulatory requirements but are frustrated when their time and energy is diverted from their primary purpose – providing quality health care to patients – to trying to decipher and comply with bureaucratic controls that often seem detached from good care and efficiency.



Currently, administrative costs – costs not associated with the delivery of patient care – comprise between \$145 and \$294 billion of our nation’s health care spending<sup>i</sup> and are a chief factor in the growth of that spending. Overall, administrative costs comprise approximately one-quarter of hospital spending.<sup>ii</sup>

It is time for dramatic change. Should all regulations be eliminated? No. Appropriate oversight is important. The issue is not whether to regulate, but how. Just as hospitals, physicians and nurses constantly work to ensure that what they do benefits patients first and makes prudent use of resources, government must do the same by standardizing requirements, being efficient in its demands and eliminating some of the redundant administrative burden placed on health care providers.

## **CURRENT CHALLENGES**

Certain laws and regulations – combined with the very complex health care payment system – make the already difficult task of operating on the front lines of American health care more challenging than it should be.

### **Financial Challenges**

Hospitals are grossly underpaid by the federal and state governments for the majority of care they provide. As a result, every dollar is precious to preserving our mission. Payment rates for Medicare and Medicaid, with the exception of managed care plans, are set by law rather than through the negotiation process used by private insurers. Hospital participation in Medicare and Medicaid is voluntary; however, as a condition of receiving federal tax exemption for providing health care to the community, hospitals are required to care for Medicare and Medicaid beneficiaries. And, unfortunately, these programs today pay less than the *cost* of providing care. Medicare reimburses hospitals only 91 cents for every dollar of care they provide to a Medicare patient. Medicaid payments are worse, reimbursing only 86 cents for each dollar of services. In 2006 alone, this combined underpayment totaled \$30 billion. That is on top of an additional \$31 billion in uncompensated care – care provided by hospitals for which no payment is received.

Unfortunately, hospitals’ financial challenges are bound to grow. Last year, the Centers for Medicare & Medicaid Services (CMS) proposed to cut hospitals’ Medicare payments for inpatient care by \$20 billion over the next three years. CMS chose to ignore the view of 269 House members and 63 senators, who specifically requested that they not make this cut. CMS claimed the cut was necessary in anticipation of how hospitals might respond to a new, refined classification system for conditions and co-morbidities.

In September Congress stepped in, passing legislation (H.R. 3668) that reduces the cuts by half over the next two years but leaves the 2010 cut of 1.8 percent intact. The changes will result in a restoration of \$2.5 billion over the next two years and \$7 billion over the next five years, assuming no additional retrospective adjustments are made. While hospitals are thankful for the relief, these cuts will still have an enormous impact.

Furthermore, President Bush's 2009 budget proposal contains nearly \$200 billion in new cuts to the Medicare and Medicaid programs over the next five years, of which \$135 billion would come from hospitals. This budget blueprint would have a disastrous impact on the health care that millions of patients and families depend on.

### **Marketplace Challenges**

In addition to this volatile payment environment, confusing changes in the marketplace are adding to hospitals' administrative burden, taking time away from providers' real work of caring for patients while driving up the cost of care and placing hospitals in an even more precarious financial position.

Myriad Insurer Requirements. There are more than 1,000 private health insurance companies in the U.S., in addition to many employers who self-insure for their employees' health care. Each of these insurers offers an array of policies, and each policy can have several combinations of covered and excluded services, patient co-payments and deductibles.<sup>iii</sup> They each have different billing forms and requirements. Most hospitals also must process claims from Medicare, Medicaid and other public programs. The result: unnecessary and redundant administrative costs.

Together, the multiplicity and redundancy of these programs represents a significant burden for hospitals. In 1999, the average U.S. hospital devoted 24.3 percent of its spending to administration.<sup>iv</sup> Studies have shown that one hour of care provided in the emergency department generates one hour of paperwork for hospital providers and administrators. Likewise, one hour of home health care generates 48 minutes of paperwork. That is unacceptable.

In an era of serious health care worker shortages, particularly when nurses, pharmacists and medical technicians are needed, we must use our caregivers' time as efficiently as possible. When health professionals find themselves spending less time devoted to bedside care and more time coping with regulatory paperwork and compliance, it is no wonder that recruiting and retaining experienced, caring professionals – much less attracting future health care workers – becomes difficult.

Medicare Advantage (MA). Changing regulations for government-sponsored plans are further adding to the confusion and burden. Over the years, Congress has made many changes to the MA program, an effort to enroll more and more seniors in private-sector insurance plans. As a result, the burden for patients and hospitals alike has grown.

Some seniors are purchasing MA coverage that they don't understand. Many seniors have approached insurers looking for new Medicare Part D drug benefit coverage. In some cases, insurers have enrolled them in their MA fee-for-service plans with drug coverage. When this happens, seniors sometimes do not understand that they are no longer in the traditional Medicare program. They may show up at the physician's office or hospital, present their old Medicare card and find that their claims are often later denied. And if a physician or hospital cares for a patient only to find out they have MA coverage, they are deemed to have agreed to the insurance company's payment, pre-

authorization and other terms. The result: more burden, more paperwork and more frustration.

### **Regulatory Challenges**

Duplicative and unnecessary regulations divert resources from patient care, increase hospitals' administrative burden and jeopardize their precarious financial position. Hospitals have about 300 external reporting requirements, many of which overlap. Nearly 30 federal agencies regulate hospitals and almost no coordination exists among them, or between similar agencies at the state and local levels. Within the Department of Health and Human Services (HHS), the major federal regulator of hospitals, at times there is little coordination among its different divisions. The following is a sample of the types of regulatory mechanisms hospitals are subject to and how, while providing a service, their lack of coordination and standardization adds to hospitals' administrative burden and drives up costs.

Recovery Audit Contractors (RACs). Ensuring the integrity of its health care programs is a key goal of the federal government as it attempts to ensure that taxpayer money is spent wisely. To that end, CMS conducts six types of activities to protect against improper payments, waste, fraud and abuse: cost report auditing, medical reviews, benefit integrity, Medicare secondary payer reviews, provider education and matching Medicare and Medicaid claims. Quality improvement organizations, fiscal intermediaries (FIs), Medicare administrative contractors, carriers, program integrity officers and RACs, among others, are all tasked with carrying out these activities to one degree or another. While each contractor has an individual purpose, they often seek the same information, requiring duplicate effort by doctors, nurses, medical record departments, patient accounting staff and other hospital personnel who must pull, review and process patient charts and appeals time and time again.

In the *Medicare Modernization Act of 2003*, Congress established the RAC program as a demonstration in California, Florida and New York to identify errors in Medicare payments – both overpayments and underpayments. Under the demonstration, RACs are paid on a contingency fee basis, receiving a percentage of the payments they collect from providers. RACs use automated proprietary software programs to identify potential payment errors, such as duplicate payments, FI mistakes and coding errors. In addition, in “complex reviews” RACs may request medical charts to review coverage, medical necessity or coding documentation for overpayments or underpayments.

In the *Tax Relief and Health Care Act of 2006*, Congress authorized the expansion of the RAC program to all 50 states by 2010. This was done before the demonstration program was complete or a thorough evaluation of its appropriateness and problems was made. So far, CMS has expanded the program to Massachusetts and South Carolina. Although hospitals support oversight for payment accuracy, we find the RAC program particularly troublesome because RACs are paid on a contingency fee basis, meaning they keep a percentage of the payments they recover, with limited risk to the RAC for making wrong decisions that unfairly hurt providers. This bounty hunter-like payment mechanism has led to aggressive denials on the part of the RACs.

Kingsbrook, for example, was aggressively targeted by the New York RAC, and many cases in which skin tissue had to be surgically removed (debridement) were denied for being incorrectly coded. In 119 cases, the RAC claimed Kingsbrook used the improper ICD-9 code because physicians did not write the word “excisional” in the medical record. The charts in question contained skin biopsy results, clearly demonstrating that skin had been removed for testing, but the RAC was unwilling to accept clinical addenda to the medical record as documentation – despite the fact that every medical/legal expert Kingsbrook consulted, including the American Health Information Management Association, said such documentation was sufficient to make a determination.

Of the denials Kingsbrook decided to appeal, 64 cases totaling \$894,000 were overturned as of December 31. Fifteen cases are still pending. While we were heartened by this, the cost to Kingsbrook in terms of money and man hours expended to overturn these erroneous denials was great. At the same time, reimbursement was withheld pending the outcome of the appeal, impeding the medical center’s cash flow. Even after winning the appeals, it took up to, if not more than, 60 days to recoup the money that we were owed in the first place.

Unbelievably, Kingsbrook has again been subjected to denials for the same documentation issue because the RAC program lacks a feedback loop. The reasons behind decisions made at the appeals stage are not communicated back to the RACs, who in turn continue to issue denials that will most likely be overturned on appeal. This is true even after a similar case has been overturned by an Administrative Law Judge.

Ironically, hospitals are told that they must learn from the process and “get smarter.” And we are undertaking every effort to do so. For example, Kingsbrook has hired additional documentation specialists to monitor clinical documentation on the floor. Unfortunately, RACs are not held to the same standards. The hospital field has asked CMS to require its contractors to develop electronic platforms for providers, the RACs, and the FIs to exchange data, medical records and outcomes on RAC audits. The development of an electronic platform is critical to fostering learning and information sharing, and reducing the burden of the RAC on providers.

This example only hints at the levels of confusion and waste – of hospital and government funds, and both hospital and CMS employees’ time – caused by duplicative efforts. Kingsbrook decided to aggressively fight back against these senseless and labor-intensive denials. However, many organizations are overwhelmed by the sheer volume of RAC requests and lack the resources necessary to pursue appeals.

Accreditation and Licensure. It is possible for a hospital to be inspected up to four times in a matter of weeks to maintain its accreditation status. First, a hospital could be inspected by The Joint Commission, which takes several days and involves many hospital staff members, pulling them away from their day-to-day duties. The hospital could then be inspected again by CMS to check on the accuracy of The Joint Commission’s surveyors. It could then be inspected a third time by a state survey agency. If the state

surveyors find something they believe The Joint Commission missed, the hospital could then be subjected to yet another inspection. These steps also are necessary to satisfy Medicare's Conditions of Participation. In addition, each state maintains its own licensure requirements and can impose their own requirements on hospitals.

Not only might a hospital be inspected multiple times, but the standards and/or interpretation of those standards often differ. For example, Kingsbrook operates an inpatient geriatric psychiatry unit. Because of the age and condition of the patients, safety is a major concern for this unit. Prior to opening the unit, we undertook a strenuous process with state regulators to determine which type of patient beds would provide both safety and prevent potential suicidal acts and, at the same time, allow for the medical needs of an older adult population with many medical co-morbidities, to be considered. The needs of these patients called for the use of traditional medical beds rather than the more typical captain beds used in a unit with younger, medically healthy patients.

The unit passed its opening inspection with the New York State Department of Health and the Office of Mental Health and yearly inspections by state accrediting agencies, as well as triennial inspections by The Joint Commission, without any mention of these beds. However, upon a CMS inspection, the agency's surveyors indicated that the beds must be removed, as they were not permitted. While we immediately complied and bore the cost of replacing the 30 beds, this has represented a hardship, and I believe a danger, for patients and staff on this unit. We are aware that there is marked inconsistency in how these regulations are interpreted and applied from institution to institution, and attempts to rectify this situation, even in part, have been met with bureaucratic rigidity or disinterest.

Quality Reporting/Pay for Performance. Strides in reporting of quality measures and the introduction of pay-for-performance programs have contributed to an increased focus on health care quality, and the data suggests, real performance improvement. But it also has increased data collection and reporting burdens for hospitals because each payer has instituted its own unique program. For example, CMS requires hospitals to report on 27 measures to receive a full annual Medicare inpatient payment update. Hospitals that fail to do so face a two percentage point reduction in their updates. Kingsbrook has had to add staff to comply with this regulation. We are fortunate to be able to make use of technology to lessen the burden on staff and ensure better outcomes on core measures.

In addition, several state Medicaid programs and private payers have launched similar initiatives. However, the measure sets are not standardized. As a result, hospitals must develop systems for tracking and reporting a multitude of quality measures to various payers.

New requirements are being added every day. For example, the *Deficit Reduction Act of 2006* (DRA) required CMS to identify at least two preventable complications of care that could cause hospital inpatients to be assigned to a higher-paying DRG and begin to pay hospitals as though the complication was not present. The DRA also required hospitals

to submit information on complications (secondary diagnoses) that are present on admission when reporting payment information for discharges to CMS.

As a result, hospitals are now required to code – for every inpatient – whether a series of conditions is “present on admission” so that CMS can try to determine whether a care complication occurred in the hospital. That means a hospital will now have to check whether a patient has one of hundreds of conditions as he or she checks into the hospital.

For many conditions, it is not always possible to know whether it is present on admission. And some of these conditions are not reasonably preventable in the first place. In an effort to create incentives for better care, this is an example of regulation applied in impractical ways with unintended consequences.

Disclosure of Financial Relationships (DFRR). In September 2007, CMS proposed a new mandatory reporting system for hospital relationships with physicians – the DFRR – that requires community hospitals to submit information on physician investments in hospitals and compensation arrangements between hospitals and physicians unrelated to whether those physicians have an investment interest. CMS stated that it would use the information to examine the compliance of each hospital with the physician self-referral law, and to assist in developing a disclosure process for all hospitals.

CMS understated the burden for responding to the compensation questions, estimating that the average burden for hospitals will be six hours. In most instances, that will not cover the time devoted just to copying the documents that need to be submitted. CMS requests information on nine different categories of compensation arrangements. For those categories most commonly engaged in (e.g., recruitment arrangements), it asks for copies of every contract in effect during a calendar year. Depending on the size of the hospital, documents will be required for hundreds or thousands of contracts.

Anecdotally, the burden estimates for hospitals also may include:

- At least 200 hours just to identify and assemble all the relevant contracts.
- Three to four weeks to fully respond, assuming no vacations or holidays for involved staff.
- Two to three months to respond with one full-time equivalent employee’s time.

Smaller hospitals will have fewer contracts, with fewer staff to complete the work, and have a greater need for outside attorneys or auditor support. In addition, hospitals with a fiscal year that is not a calendar year are required to include arrangements from two fiscal years, doubling their workload.

CMS seems to believe that electronic record systems have been created specific to the terms of the DFRR, and the threat of a \$10,000-per-day penalty for late responses suggests that hospitals had a pre-existing duty to anticipate this type of demand. This is simply not the case.

CMS' justification for this survey relies largely on the DRA, which directed CMS to “develop a strategic and implementing plan” to address issues of concern to Congress regarding “physician investment in specialty hospitals” as the basis for its action. This is a laudable goal with which we agree. However, the DRA did *not* direct CMS to study compensation arrangements between community hospitals and physicians. CMS has not demonstrated a problem or concern that would merit this costly and burdensome demand on community hospitals.

Translation of Medicare Beneficiary Notices and Forms. Language barriers can have a detrimental effect on the health care of those in racial/ethnic minority groups and immigrants. Health care providers, as well as the federal government, are required to provide language services to federal program participants who have limited English proficiency (LEP) to ensure that they are able to benefit from these programs under *Title VI of the Civil Rights Act of 1964* and under *Executive Order 13166 on Improving Access to Services for Persons with Limited English Proficiency*, signed by President Clinton on August 16, 2000.

As with the U.S. population as a whole, the number of Medicare LEP beneficiaries is growing. According to the U.S. Census Bureau's American Community Survey, in 2003 there were 2.5 million people over the age of 65 in the United States with LEP. About half are Spanish-speaking. The number of other languages is growing rapidly.

Hospitals and others have pressed CMS for years to provide a centralized bank of translations of key Medicare beneficiary notices and forms in the languages that are most frequently encountered by health care providers – to no avail. CMS sometimes provides translations in Spanish, but not in other languages. Health care providers are prohibited from changing any of the language in these notices, except to fill in individual patient information. Because CMS will not provide translations, hospitals are faced with having to do so individually. This painstaking process diverts time and resources.

## **REDUCING THE BURDEN**

The AHA, its member hospitals and health systems, and the millions who work within these facilities urge the administration and Congress to work together to ease the regulatory burden confronting health care providers. A necessary first step is to create a more common-sense approach to developing and issuing future regulations. Equally critical, though, is the need to quickly provide relief from the most burdensome, inefficient or ineffective regulations – those that take away from critical time spent with patients.

Halt and Evaluate the RAC Program. Hospitals are committed to doing the right thing the first time to ensure quality, patient safety and payment accuracy. However, duplicative oversight mechanisms only increase confusion and drive up costs for both hospitals and the health care system as a whole, as well as the government.

Hospitals are deeply concerned about the Medicare RAC program. We believe CMS should not expand the RAC program until a full assessment of the demonstration is completed and major program flaws are corrected. The AHA has shared with CMS hospitals' concerns about the demonstration program and proposed rollout plan and continues to urge the agency to make changes before rolling out a permanent RAC program to all 50 states. In addition, Reps. Lois Capps (D-CA) and Devin Nunes (R-CA) introduced H.R. 4105, the *Medicare Recovery Audit Contractor Program Moratorium Act of 2007*, which would place a one-year moratorium on RAC activities in states in which RACs are currently operating and prevent CMS from entering into new RAC contracts in other states. By delaying implementation, the moratorium would allow time for program evaluation and time to address serious problems with RACs, including more appropriate payment incentives, and greater oversight and transparency.

Evaluate New Agency Requirements. Government agencies should be required, as part of any proposed rulemaking process or other change in agency policy, to undertake a rigorous examination of existing mechanisms for waste and duplication, and fully justify the value of each new agency or oversight program. As part of any new or proposed regulatory change process, agencies should be asked to identify areas of potential overlap or duplication with other government or private activity. We need smarter rather than greater regulation and oversight.

Provide Interpretive and Advisory Guidance on Medicare Payment Requirements. Medicare requirements for provider participation and payment are increasingly voluminous and complex, making compliance difficult, while penalties for compliance failures are increasingly severe. CMS should establish query mechanisms for individual providers and their associations on the appropriate interpretation or application of Medicare rules in specific situations. CMS' responses should be timely and readily available to others in an easily accessible format (such as an indexed file on the Internet).

Include the Cost of Implementing Significant Regulations into Medicare Payment Updates. The initial cost of implementing significant new regulations is not captured by Medicare prospective payment rate updates. Like new technology and productivity improvements, these costs should be taken into account by the Medicare Payment Advisory Commission when it makes its annual rate update recommendations to Congress.

Enable Providers to Challenge Questionable Policy Actions in Court. Unlike other federal agencies, Medicare program policy decisions made by the Secretary of HHS are insulated from judicial review. Health care providers are required to exhaust all administrative processes and remedies before they can file suit against HHS. However, there is no such process to exhaust on questions about whether the Secretary has exceeded his authority or failed in his duty. This effectively means that providers can bring a suit only if they violate Medicare requirements so significantly that they are thrown out of the Medicare program. HHS policy decisions should be subject to the same level of judicial review as other federal regulatory agencies.

Coordinate the Orderly Release of Federal Regulations to Allow for More Seamless Compliance. Government agencies with jurisdiction over hospitals need to release regulations in a coordinated manner so that implementation does not overwhelm hospital personnel and systems. That means establishing a point of accountability to coordinate regulatory activity across major federal agencies, as well as within HHS. As the predominant federal regulator of hospitals, HHS should periodically evaluate its overall federal regulatory framework applied to health care providers for clarity and expected behavior from providers.

Seek Greater Provider Input on New Rules and Regulations. Federal regulators need to become more acquainted with real-world hospital operating environments so that practical implementation issues can be minimized before a regulation goes into place. Agencies should conduct outreach efforts to obtain early input from the health care field, including publishing notices of intent; making relevant databases, cost estimates, assumptions, and methodologies publicly available early on; holding field hearings; and conducting site visits.

Restrict Use of Interim Final Rules. HHS has increasingly issued new rules as interim final rules; that is, issued and implemented before the agency takes public comment. To reduce the disadvantages of this approach – which negates the public comment process – HHS should be required to issue final rules within a year.

Make Translations of Medicare Beneficiary Notices and Forms Routinely Available. It would be significantly more efficient for CMS to prepare translations and then make them available to health care providers via their Web site. The Social Security Administration does this through its multi-language gateway for 15 languages, and the Department of Agriculture makes food stamp forms available in 36 languages. Individual providers translating routine forms is an increasingly heavy burden, especially for small health care providers.

## **CONCLUSION**

Madame Chairwoman, the mission of every hospital in every community in America is to provide the best care possible to people in need. And while regulation and oversight play an important role in guaranteeing patient safety and eliminating fraud and abuse, many of today's regulations are outdated, inefficient and burdensome.

We look forward to working with this committee and staff to forge ahead toward a shared goal: easing the regulatory burden so the people of America's hospitals can spend more time with patients and less time with paperwork.

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<sup>i</sup>Peterson, C. L., and Burton, R. U.S. Health Care Spending: Comparison with Other OECD Countries. Congressional Research Service. 2007; Woolhandler, S., Campbell, T., and Himmelstein, D. U. Costs of health care administration in the United States and Canada. *New England Journal of Medicine*. 349(8):768-775, August 21, 2003.

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<sup>ii</sup> Woolhandler, S., and Himmelstein, D. U. Costs of care and administration at for-profit and other hospitals in the United States. *New England Journal of Medicine*. 336(11):769-774, March 13, 1997; erratum in 337(24):1783, December 11, 1997.

<sup>iii</sup> Jesse, W. F., "Keep it Simple, Stupid. Administrative complexity raises costs, frustrates patients and hampers care." *MGMA Connexion*. 4(3):36-41, March 2004.

<sup>iv</sup> Woolhandler, S., Campbell, T., and Himmelstein, D. U. Costs of health care administration in the United States and Canada. *New England Journal of Medicine*. 349(8):768-775, August 21, 2003.