

STAT: TACKLING TODAY'S CHALLENGES

Reducing Regulatory Burden

Issue

Every time nurses, physicians, and other health care workers care for a patient, a host of regulations and statutes governs their efforts. More than 30 agencies oversee some aspect of the health care delivery process at the federal level alone. No one questions the need for some regulation. But we need to make sure that the regulatory process doesn't put paperwork and red tape between caregivers and their patients.

With the support of the AHA's Task Force on Regulatory Reform and Relief and hospitals and health systems across the country, we've made tremendous strides during the past two years in convincing the federal government that the regulatory maze hospitals deal with is complex, redundant and defies common sense. Heeding hospitals' concerns, the Department of Health and Human Services (HHS) has carried out a stream of measures to ease regulatory burdens. They include: eliminating the minimum data set requirement for critical access swing bed hospitals, streamlining paperwork requirements for non-critical access swing bed hospitals, and beginning to identify ways to reduce the size and scope of the Medicare cost report. In addition, the Centers for Medicare & Medicaid Services (CMS) has issued clearer guidance on hospitals' obligations under the Emergency Medical Treatment and Labor Act (EMTALA). Finally, the Medicare Modernization Act included many of the AHA's recommended changes, such as reforms to EMTALA and Medicare Secondary Payer (MSP), as well as prohibited federal agencies from including new provisions in a final rule that are not a "logical outgrowth" of the proposed rule.

AHA View

While we have made progress in advancing regulatory relief, more work needs to be done. The AHA will continue to build on the strong foundation we have laid with the Bush Administration and Congress to achieve a regulatory environment that puts patients first, not paperwork. We will address hospitals' regulatory burdens in many ways in 2004, including:

HIPAA. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established new standards for the movement and uses of health care information. There are three types of standards created by HIPAA: privacy, security and administrative simplification (e.g., transaction standards). Taken together, these regulations have a major impact on the day-to-day functioning of the nation's hospitals and affect virtually every department of every entity that provides or pays for health care.

Privacy. The AHA will continue to work with the HHS Office of Civil Rights (OCR) to streamline and clarify certain aspects of the medical privacy rule. Hospitals are required by law to report to public health authorities information for dozens of widely accepted health-related purposes, such as tracking births, deaths, cancer patterns, child abuse and defects in medical devices. The HIPAA accounting of disclosures provision currently requires hospitals to create a burdensome paperwork system to track such disclosures, regardless of whether any patient ever requests such an accounting. The AHA is aggressively pushing a practical regulatory change to



the HIPAA regulations to ensure that patients understand what personal information hospitals are required to disclose to public agencies while reducing paperwork burdens for already overburdened hospitals.

The AHA also supports streamlining HIPAA's business associate requirements by eliminating the superfluous and burdensome administrative requirement for business associate agreements between covered entities that are already subject to the requirements of the privacy rule.

Transactions Standards. As the migration to standard transactions continues, the AHA is urging the administration to ensure that contingency plans that allow providers to continue to receive payment for the claims they submit remain in place and enforcement efforts be conducted with an eye toward the overriding obligation to continue claims processing.

In addition, the AHA believes that claims should not be rejected simply because they are missing data or include incorrect data that payers do not need in order to process and pay the claims. Rejection of health care claims that are in the proper format and contain all the data necessary for the health plan to process and pay the claims and the resulting disruption of provider payments violates Congress' mandate of increasing efficiency and reducing costs in health care administration.

The AHA urges that revisions of current standards and all future standards in development ensure that data content requirements are based on business necessity; are consistent with the requirements and goals of administrative simplification; minimize data collection burdens; and distribute that burden proportionally to all parties involved in the claims process.

Security. As hospitals work to implement the HIPAA security rule by the April 2005 compliance deadline, the AHA will focus on ensuring that interpretation and enforcement of the security requirements remain consistent with the flexible and scalable approach adopted in the regulation.

OIG Rule on Hospital Charges. The AHA is aggressively calling for the HHS Office of Inspector General (OIG) to withdraw its proposed rule on what it inaccurately calls "excessive charges." Under the OIG proposal, charges will be deemed "substantially in excess" if a provider's charges to Medicare (measured as the amount recorded in a hospital's charge master) are more than 120 percent of the average payment received from private payers or self-pay patients. Violators may be subject to exclusion from the Medicare program. The proposal's flawed definition and methodology for determining when a provider's claim for payment violates the rule mixes apples and oranges by comparing charges on a Medicare claim with payments received by non-Medicare payers. The rule's flawed methodology would impose an unworkable, burdensome and extraordinarily costly regimen for hospitals, all without benefit to the Medicare Program or America's elderly. If a final rule is issued, the AHA will take appropriate next steps to provide hospitals relief from this misguided regulation.



Local Medical Review Policies for Rehab Patients. During the past six months, several fiscal intermediaries (FI) have released draft local medical review policies (LMRPs) and local coverage determinations (LCDs) to elaborate on federal regulations that determine eligibility for Medicare inpatient rehabilitation coverage. Many of these LMRP/LCD proposals would impose unreasonably narrow and clinically unsupported medical necessity guidelines that would significantly reduce access to care. In conference report language in the Consolidated Appropriations Act of 2004, Congress directed CMS to halt LMRP/LCD activity while it contracts with the Institute of Medicine (IOM) to convene a panel of medical rehabilitation experts to establish a clinical consensus on whether and how to modify existing inpatient rehabilitation medical necessity criteria. CMS has not acted on this congressional directive. Pending analysis by the IOM panel, the AHA is urging CMS to instruct its FIs to delay action on the LMRPs/LCDs.

Model Practices. The AHA will continue to work collaboratively with CMS to identify confusing and conflicting regulations. Through the work of our model practices group, the AHA identifies an issue that needs clarification, develops proposed guidance and confers with CMS on the appropriate interpretation. CMS' clarification is then shared with AHA members and the field more generally. Model practices led to the agency's recent clarification of the Stark II regulations addressing federal physician self-referral rules and its guidance on which practitioners can order diagnostic tests in a hospital setting. The model practices project reduces the potential for misinterpretations, while at the same time minimizing the costs and burden for individual hospitals to obtain clarifications.

Certification for Alien Health Care Workers. Effective July 26, the Department of Homeland Security (DHS) will require alien health care workers to present a certificate issued by the Council of Graduate Foreign Nursing Schools to work or continue working in the U.S. The certification process is lengthy and in certain circumstances, redundant. Nursing experts estimate it could affect up to 15,000 nurses who are licensed and working in the U.S. At a time of a serious nationwide shortage of caregivers, the rule would thwart hospitals' efforts to recruit and retain highly qualified personnel. The AHA is urging DHS to delay implementation of this new regulation, and some senators agree. In a letter to DHS Secretary Tom Ridge, Sen. Saxby Chambliss (R-GA), chairman of the Senate Judiciary Committee's immigration panel, and a bipartisan group of 13 senators, urged DHS to delay to October 1, 2005 the effective date of the regulation.

