

## Regulatory Relief

### Background

Every time nurses, physicians and other caregivers treat a patient, a host of regulations and statutes govern their actions, especially if the patient is a Medicare or Medicaid beneficiary. More than 30 agencies oversee some aspect of the health care delivery process at the federal level alone. No one questions the need for regulations to ensure safe patient care. However, excessive regulations, outdated laws and a lack of clear federal guidance can combine to inhibit the innovation and cooperation essential to realizing the promise of better care delivery to which America's hospitals are committed. They also drain time, funding and attention that could more effectively be focused on patient care.

### AHA View

The AHA is concerned about the mounting regulatory burden faced by America's hospitals and its impact on patients and communities. We have identified the following areas and associated regulations that impede hospitals' ability to provide care to their communities: clinical integration, Recovery Audit Contractors (RACs), the False Claims Act (FCA) and federal incentives for adoption of electronic health records (EHRs).

**Clinical Integration.** Clinical integration is needed to facilitate the coordination of patient care across conditions, providers, settings and time to achieve care that is safe, timely, effective, efficient, equitable and patient-focused. At its heart, clinical integration is teamwork: hospitals, doctors, nurses and other caregivers working together to make sure patients get the right care, at the right time, in the right place. Hospitals are trying to spur this kind of teamwork, but regulatory barriers stand in the way. The barriers to clinical integration range from confusing antitrust policies to outdated rules governing relationships between hospitals, doctors and other caregivers. Even Internal Revenue Service (IRS) rules can be a barrier because they are applied by an agency largely removed from health care delivery and how it is evolving.

There are solutions. They range from creating user-friendly antitrust guidelines and safe harbors, to providing clear congressional direction on existing rules that promote instead of hinder clinical integration efforts. The AHA has identified specific barriers and provided suggested solutions to the Administration. Refer to the AHA's issue paper "Clinical Integration" for an in-depth analysis.

**Recovery Audit Contractors.** RACs were authorized as a Medicare demonstration program under the *Medicare Modernization Act of 2003*, and made permanent by the *Tax Relief and Health Care Act of 2006*. They are charged with identifying improper Medicare fee-for-service payments – both overpayments and underpayments. RACs are paid on a contingency fee basis, receiving a percentage of the improper payments they identify and collect. RACs were extended to the Medicaid program through the *Patient Protection and Affordable Care Act*. The Medicare RAC demonstration program suffered from improper oversight by

the Centers for Medicare & Medicaid Services (CMS) and resulted in overzealous claim denials. The fundamental flaws in the design and operation of the Medicare RAC demonstration program led to provider appeals, 64 percent of which were decided in favor of the provider.

Hospitals strive for payment accuracy and are committed to working with CMS to ensure the accuracy of Medicare and Medicaid payments; however, the flood of new auditing programs, such as RACs, has subjected hospitals to duplicative audits, unmanageable medical record requests and inappropriate payment denials. Policymakers must make improvements to the RAC program to reduce the administrative burden of a program that is serving only to divert resources from patient care and contribute to growing health care costs. More than 50 percent of hospitals report a significant increase in administrative burden due to the RAC program, including employing additional compliance staff and consultants.

RACs should target only legitimate payment mistakes and should be prohibited from issuing medical necessity denials, which invalidate the medical judgment of a trained health care professional and force hospitals into the costly and complex Medicare appeals process. If medical necessity review is allowed to continue in the RAC program, CMS must be required to establish a process for re-billing denials at the alternative level of care or code determined by a RAC (e.g., inpatient to outpatient). Requirements for deductibles, co-pays and benefits should be waived to prevent any new beneficiary liability. In addition, CMS must take more steps to accomplish the goal of the RAC program – reducing improper payments. CMS should reinvest 7 percent of the RAC program recoveries into payment system fixes and provider education.

With regard to Medicaid RACs, states that already have Medicaid auditing programs and states with Medicaid managed care organizations should not be required to adopt a Medicaid RAC program. In states where CMS requires implementation of a Medicaid RAC program, Congress should require CMS to adopt program restrictions that limit administrative burden, duplicative audits, and aggressive and inappropriate RAC audits.

**Abuse of the False Claims Act.** The Department of Justice and certain Assistant United States Attorneys are abusing their authority by initiating FCA investigations of hospitals upon the discovery of evidence of a mistake or overutilization. These government officials have seized upon data analysis that flags billing errors and converted it into a presumption of FCA liability. FCA cases pose great risk to hospitals in terms of monetary and administrative sanctions. The threat of FCA liability leads hospitals to incur massive expenses related to retaining specialized counsel and outside forensic accountants and, in the event an overpayment is discovered, to negotiate a formal FCA settlement where a simple cost report adjustment is all that is really necessary.

**Medicare and Medicaid EHR Incentives and Certification.** Use of EHRs can improve care quality, efficiency and coordination. Hospitals have been leaders in health information technology (IT) adoption and use. But the high cost of acquiring and maintaining these systems has been the key barrier for broader hospital adoption. *The American Recovery and Reinvestment Act of 2009* authorized incentive programs under Medicare and Medicaid that will pay bonuses to “meaningful users” of certified EHRs beginning in fiscal year (FY) 2011, then phase-in penalties for those failing to meet “meaningful use” beginning in FY 2015. To be eligible for the incentives, hospitals must use EHRs that have been certified through a new federal process established by the Office of the National Coordinator for Health Information Technology (ONC).

When Congress enacted this landmark program, hospital leaders were excited about the opportunity to be rewarded for their efforts to adopt health IT. However, the rules set out to manage this program are overly complex and confusing, leaving many hospitals concerned about their ability to meet the programs’ demands. In a January AHA survey, 53 percent of hospitals cited lack of clarity in regulatory requirements as a barrier to achieving meaningful use in a timely manner, while 52 percent cited complexity as a barrier. These barriers were cited slightly more often than upfront capital costs (52 percent) and ongoing costs (51 percent). Simplified regulations that recognize how health IT is really acquired, used and implemented are needed for this program to fully succeed and for hospitals to be able to meet the national goals of an e-enabled health care system. Refer to the AHA’s issue paper “Health Information Technology” for an in-depth analysis.