

Regulatory Relief

Issue:

In an environment of diminishing financial resources, Illinois hospitals continue to be burdened by regulations that are in many instances duplicative, archaic or even conflicting. Hospitals invest significant amounts of time and resources to simply “keep up” with regulations. As Congress continues to examine legislation designed to improve efficiency and value in the delivery of healthcare services, it must reduce, or eliminate regulations that do not improve the quality of care provided to patients, yet require hospitals to expend precious resources implementing them, resulting in additional costs and inefficiencies in the system.

Background:

In previous years, the Centers for Medicare and Medicaid Services (CMS) has promulgated regulations addressing the following that have added regulatory burdens for hospitals:

- **Services provided at off campus, hospital-based outpatient departments (HOPDs);**
- **Professional services payment reform, as legislated by the Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program (QPP);**
- **Incorporation of Medicare cost report Worksheet S-10 into the Uncompensated Care component of the Medicare Disproportionate Share (DSH) payment methodology;**
- **Direct supervision of certain hospital outpatient therapeutic services;**
- **96-hour attestation requirement for Critical Access Hospital Medicare admissions; and**
- **New, value-based Medicare payment models, which necessitate reform of the current Stark law.**

Action Requested:

- Require Medicare Administrative Contractors (MACs) to extend the site-neutral exception opportunity to those HOPDs that *relocated* after November 2, 2015;
- Delay implementation of Worksheet S-10 until CMS publishes its S-10 audit protocol and clarifies its definitions and instructions for completion and submission of that worksheet;
- Create “hold-harmless” provisions for those eligible providers still struggling with the implementation of the provisions of the QPP, most notably, the registration and performance reporting requirements;
- Permanently repeal the direct supervision and 96-hour attestation requirements currently placed on rural hospitals, as these regulations lead to reduced access to services for Medicare beneficiaries;
- Remove geographic coverage barriers for telehealth services to help create access to care for the 77% of Medicare beneficiaries who live outside of major metropolitan statistical areas;
- Delay implementation of periodic post-payment reviews of telehealth claims until MACs have implemented all telehealth claim edits listed in the Medicare Claims Processing Manual, and ensure reviews do not require additional records to document telehealth services that would not otherwise be required for in-person claims; and
- Amend the current Stark law to better encourage providers to collaborate in order to facilitate more participation in CMS’ increasing emphasis on value-based payment models for Medicare services.

For more information, contact:

Cristina Batt, Vice President, Federal Government Relations | cbatt@team-iha.org | 202.624.7899