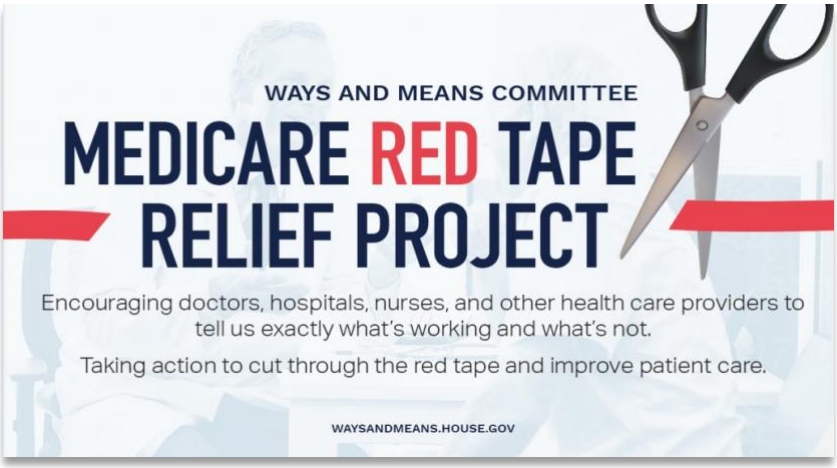
MEDICARE RED TAPE RELIEF

As a part of the Committee on Ways and Means' ongoing effort to modernize and improve the Medicare program for American seniors and the providers that serve them, the Committee launched the Medicare Red Tape Relief Project. This initiative seeks to identify opportunities to reduce legislative and regulatory burdens on Medicare providers, improving the efficiency and quality of the Medicare program for seniors and individuals with disabilities.



This document provides an overview of the Committee's efforts to date as well as potential next steps to deliver relief from the unnecessary regulations and mandates that impede innovation, drive up costs, and ultimately stand in the way of delivering better care for Medicare beneficiaries.

OVERVIEW

Congress often hears about "regulatory burden" but all too often this term is ignored in relation to the Medicare program. As such, the Committee sought to better understand what this term actually means and how it can be addressed. Regulations have their place and are important to ensuring quality, integrity, access, and safety in our health care system. But, if rules are misguided, outdated, or overly complex, they can have a suffocating effect on health care delivery by shifting the focus of providers away from the patient's needs and toward unnecessary paperwork, and ultimately increase the cost of care. When burdensome regulations detract from patient

care, Congress should look to improve on them or eliminate them entirely.

It's no surprise that the Centers for Medicare and Medicaid Services (CMS) publishes nearly 11,000 pages of regulations every year.[1] That's a lot of paper…and it's taking health care providers away from what matters most – patients.

Providers are spending too much time, and too many dollars, complying with the many rules layered upon other rules. It is driving up the cost of patient care and creating barriers to innovation in the Medicare program.

The American Hospital Association published a report[2] showing that health systems, hospitals, and post-acute care (PAC) providers must comply with 629 mandatory regulatory requirements, and these entities spend nearly $39 billion a year solely on administrative activities. This report also showed that an average size hospital dedicates 59 full-time employees to regulatory compliance, over one quarter of whom are doctors and nurses.

Recently a study[3] in the *Annals of Internal Medicine* found that physicians spend nearly two additional hours of paperwork for every hour they were seeing patients. These numbers cannot possibly reflect the purpose of the reporting regulations passed by Congress.

Despite all of this regulation we have not bent the health care cost curve. Health care spending is actually growing more quickly now than it was in the year in which the Affordable Care Act was passed. If we continue on this path, by 2026 we will be spending one in every five dollars on health care. Our health care system is on an unsustainable trajectory.[4]

According to one report[5], administrative costs, including those associated with adopting and complying with health care regulations, account for 25 percent of annual hospital spending in the United States, which amounts to more than $200 billion. In fact, the United States had the highest hospital administrative costs when compared to seven other major Western countries.

The Ways and Means Committee has been listening. Under the Medicare Red Tape Relief Project, the Committee is looking for ways to streamline regulatory requirements, reduce unnecessary burden and increase efficiencies both through regulatory or statutory means in order to better generate innovation, improve the patient experience, and enhance the quality of care for Medicare beneficiaries.

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[1] "Patients over Paperwork—Burden Reduction," *YouTube*, December 5, 2017, https://www.youtube.com/watch?time_continue=7&v=83bm-CNp2a8

[2] "Regulatory Overload Report: Assessing the Regulatory Burden on Health Systems, Hospitals, and Post-Acute Care Providers," American Hospital Association, October 2017, https://www.aha.org/system/files/2018-02/regulatory-overload-report.pdf

[3] C. Sinsky and L. Cooligan et al., "Allocation of Physician Time in Ambulatory Practice: A Time in Motion Study in Four Specialties," Annals of Internal medicine, December 2016, http://annals.org/aim/article-abstract/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties

[4] "National Health Expenditure projections 2017-2026," Cms.gov, February 2018, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ForecastSummary.pdf

[5] D.U. Himmelstein, M. Jun, and R. Busse et al., "A comparison of hospital administrative costs in eight nations: U.S. costs exceed all others by far," *Health Affairs*, 33(9): 1586-94, 2014

The Ways and Means Committee has invited a two-way discussion with doctors, hospitals, PAC providers, and other health care professionals about how we can accomplish the shared goal of empowering providers to deliver the best quality care to their patients.

The Project has three stages:

1. **Stage One: Request feedback from stakeholders** to learn more about the policies that improve health care – and the policies that stand in the way;
2. **Stage Two: Host roundtables with stakeholders** to continue the conversations and identify solutions; and
3. **Stage Three: Take Congressional action** based on feedback from stakeholders and dialogue with the Administration.

ENGAGEMENT OF HEALTH CARE PROVIDERS

The Ways and Means Committee, both at the Member and staff level, has hosted dozens of meetings and phone calls and a handful of roundtable discussions to hear from providers on the front lines.

The Committee is serious about reducing burden and ensuring that health care providers are able to maximize time with patients and focus on patient care. The Committee is asking health care providers on a regular basis, "which burdens and documentation requirements are taking away the most time from patient care?"

STAGE ONE OF STAKEHOLDER ENGAGEMENT: REQUEST FOR INFORMATION

Just over a year ago, on July 24, 2017, the Committee announced this initiative and asked stakeholders to submit comments on the regulatory and statutory burdens they face. In response, the Committee received over 500 individual submissions to the Red Tape Relief Project, with over 300 unique organizations submitting thousands of pages of comments and data.

The following number of groups and organizations responded with Red Tape Relief comments:

- 158 clinicians and clinician groups
- 101 hospital and facility groups
- 22 drug and medical device groups
- 13 ambulance groups
- 11 insurance groups
- 10 major health systems
- 8 home health groups
- 6 health information groups
- 5 Medicare advocacy groups
- 5 other advocacy groups

At the Ways and Means Committee, we want to know the impact of current regulations, which is why we reviewed all of our Medicare Red Tape Relief Project Request for Information (RFI) comments and evaluated many

regulations and statutory requirements, asking:

- What's the purpose?
- Is this required by Congress or CMS? Why?
- Does it make sense? Does it help us prevent fraud and abuse?
- Is it duplicative?
- Does it meaningfully impact patient care and safety or improve outcomes?
- If not, then why do we have the regulation or statutory requirement in the first place?

We know that the current collection of regulations and requirements that govern health care is overwhelming and driving up costs.

For example, across the hospital quality reporting programs, inpatient hospitals report over 80 quality measures. And at least a dozen of these measures are "chart abstracted," meaning that hospital staff must manually enter the values.

Separately, many clinicians have to report nearly 30 measures to 7 different payers, which again leads to less time focused on patients and is contributing to clinician burnout. Providers are frustrated because they got into the health care field to directly care for patients, yet documentation and administrative tasks continue to take greater amounts of time, which could have been time spent with patients. Meanwhile, patients and their families often wait hours or weeks just to get one-on-one time with their clinician.

The Committee recognizes there is a big opportunity to improve patient care and reduce health care costs by alleviating providers from certain burdens that detract from patient care.

STAGE TWO OF STAKEHOLDER ENGAGEMENT: MEMBER AND STAKEHOLDER ROUNDTABLE DISCUSSIONS

Ways and Means Committee staff have maintained an open-door policy as part of the Red Tape Relief Project. They have met with numerous stakeholders and health care providers to review how to reduce regulatory burdens. Members have taken a number of meetings focused on these issues as well. Finally, the Committee, led by Health Subcommittee Chairman Peter Roskam, convened multiple bipartisan roundtable discussions.

On March 15, 2018, the Committee invited physician stakeholders to join a bipartisan roundtable discussion with Members. With groups representing nearly all practicing physicians and medical groups present, Members heard about the issues that were keeping patients from being the central focus point due to over-burdensome regulations.

A sampling of major issues that were discussed includes:

- Improving perceived overutilization of prior authorization by health plans for both drugs and services;

- Modernizing long unchanged statutes standing in the way of greater value-based care such as Stark and anti-kickback laws;
- Standardizing enrollment and billing as well as eliminating duplicative administrative tasks;
- Enrollment and billing standardization and the elimination of duplicative administrative tasks; and
- Allowing for the expanded use of innovation to reduce burdens and access issues such as telehealth services.

Due to the robust discussion and unrelated time constraints during the March 15 session, on June 14, 2018 the Committee reconvened the completed discussion with clinicians and Members, once again engaging with the stakeholders on these issues. The extended discussion provided clinicians and the Members the opportunity to discuss not only the problems they face but also what common-sense solutions could be derived both through the regulatory and statutory process.

On April 11, 2018, the Committee invited hospital stakeholders to join a bipartisan discussion with our Members. A variety of hospitals from all over the country presented regulatory challenges that distract from patient care. A sampling of major issues that were discussed includes:

- Improving hospital conditions of participation;
- Removing barriers to promote coordinated care and innovative care models;
- Removing barriers to care in rural areas;
- Streamlining hospital quality reporting;
- Improving hospital star ratings; and
- Ensuring the Medicare program is only using meaningful measures that truly reflect high quality care and patient outcomes.

On May 22, 2018, the Committee convened a bipartisan roundtable that focused on administrative burdens in the PAC setting. The Committee heard from different types of PAC providers and a beneficiary group. Long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), home health agencies (HHAs), and hospice providers each focused on burdens unique to each setting of care and workflow challenges that get in the way of patient care within each PAC setting.

A sampling of major PAC issues the Committee heard about includes:

- Reducing burdens based on arbitrary numbers set by the federal government (e.g. the 25 percent rule for LTCHs. We are pleased to see CMS recently finalized their proposal to eliminate this burdensome regulatory requirement in FY 2019);
- Removing barriers that get in the way of training and staffing of health care professionals;
- Improving engagement, education and transparency between CMS and PAC providers;
- Improving and streamlining certain billing processes and documentation requirements;
- Increasing flexibility in correcting minor errors in claim submissions; and
- Improving the flexibility for certain health care services and requirements.

Broadly, in the Committee's meetings, roundtable discussions, and RFI comments health care providers coalesced around the following major issues and themes:

- Remove red tape that distracts providers from *patient care;*

- Remove red tape that increases the *costs of health care;*
- Remove red tape to *improve access to care;*
- Remove red tape that stands in the way of *modernizing the Medicare program;*
- Remove red tape that stands in the way of *streamlining and coordinating care;*
- Remove red tape that stands in the way of *transparency for providers and beneficiaries; and*
- Remove red tape that burdens facilities with reduced staffing and exacerbates the *shortage of health care workers.*

While many issues are specific to certain provider types, the Committee found many overlapping themes and issues that cut across all provider groups, including:

1. The need for improved flexibility to provide telehealth services;
2. Challenges associated with the Stark Law; and
3. Documentation and reporting burdens, among other issues.

STAGE THREE OF STAKEHOLDER ENGAGEMENT: TAKING CONGRESSIONAL ACTION

On July 17, 2018, due to the overwhelming and unifying concerns from stakeholders, the Committee convened a hearing to discuss the need to modernize Stark Law in order to break down barriers to value-based care that currently exist due to this law. The Committee's Subcommittee on Health invited both the Deputy Secretary of the Department of Health and Human Services (HHS) Eric Hargan as well as provider witnesses to shed more light on the topic. The hearing highlighted this law's unintended consequence of driving up costs for patients and creating unnecessary complexity and regulatory stress for providers as well as the lack of modernization standing in the way of greatly expanding access to more value-based coordinated care. On a bipartisan basis, Members agreed on the shared goal of moving to more value-based care for patients. The Committee is considering next steps on this important stage as it moves through regular order.

ENGAGEMENT WITH ADMINISTRATION

In June 2018, the Ways and Means Committee engaged in discussions with the CMS on the major regulatory relief issues brought to the Committee by stakeholders. CMS also provided the Committee with policies brought to its attention through their Patients over Paperwork initiative that they believed to be legislative in nature. This resulted in an insightful and robust discussion on regulatory issues related to hospitals, PAC providers, physicians, and other providers. The Committee commended CMS on steps they have taken to reduce provider burden under the current Administration, while also engaging CMS to identify where the agency can do more to further cut down on regulatory burden. This continues to be an ongoing dialogue with CMS and HHS.

TAKING CONGRESSIONAL ACTION, PART ONE: REGULATORY OR STATUTORY ACTION NEEDED?

The Committee's discussion with CMS provided greater insight about which burden reduction policies will likely require legislative action. In other words, the Committee will determine where certain legislative policies could untie CMS's hands in order to better achieve burden reduction for providers, especially those that would enhance patient care and/or help bend the health care cost curve. This discussion also continues to be an ongoing dialogue with CMS and HHS.

TAKING CONGRESSIONAL ACTION, PART TWO: APPLAUD CMS FOR TAKING STEPS TO REDUCE PROVIDER BURDEN AND REQUEST THE AGENCY TAKE ADDITIONAL ACTION THROUGH ONGOING CONVERSATIONS AND PUBLIC LETTERS.

Specifically, the Committee is sending four letters to CMS to highlight the following:

- **Hospital:** (1) Acknowledge the Committee's appreciation for the Administration's burden reduction efforts in the Inpatient Prospective Payment System Final Rule; (2) improve how CMS enforces the hospital conditions of participation; (3) reform hospital star ratings; and (4) build on the meaningful measures initiative.
- **Post-acute care (PAC):** Acknowledge the Committee's appreciation for the Administration's burden reduction efforts in each of the payment rules for PAC settings of care and highlight at least one unique burden faced by each individual PAC provider.
- **Physician and Ancillary Services:** (1) Acknowledge the Committee's appreciation for the Administration's burden reduction efforts in the recent Hospital Outpatient Prospective Payment System, Physician Fee schedule, Durable Medical Equipment, and End-Stage Renal Disease regulations; (2) express appreciation for the coordinated effort on modernizing Stark Laws; (3) standardize reporting and billing authorization requirements; and (4) build on the Administration's start to increased coordination between Agencies within HHS to reduce burden.
- **Rural:** Acknowledge the Committee's appreciation for the Administration's burden reduction efforts and highlight more work on a handful of administrative burdens that have a big impact on rural areas.

TAKING CONGRESSIONAL ACTION, PART THREE: LEGISLATIVE SOLUTIONS

The Committee's work is not complete. The health care landscape is constantly changing, which will require policymakers to continuously weigh the impacts to the provider community, and most important of all, the impact on patient care.

This is not to mean that the Committee has not already begun the process of regulatory relief through the statutory process.

Last Congress H.R. 3831, the *Securing Fairness in Regulatory Timing Act of 2015*, introduced by Chairman Brady was signed into law, giving stakeholders relief they had requested for some time. This allowed for additional time beginning in 2018 for stakeholders to review and comment on Medicare Advantage and Part D regulations.

As part of the *Bipartisan Budget Act of 2018*, several policies were signed into law addressing issues that had received significant stakeholder comment, including:

- H.R. 3120, to reduce annual burdens under the meaningful use program, which was statutorily required to become more stringent every year.
- H.R. 3178, the *Medicare Part B Improvement Act of 2017*, was passed including several provisions:
    - H.R. 3171, which streamlined rules to protect patients' access to prosthetics for patients who need them.
    - H.R. 3166, which removed regulatory burdens in accreditation for dialysis facilities to expand access for vulnerable patients.
    - H.R. 3164, which expanded the availability of telehealth for patients receiving dialysis in their homes.
    - H.R. 3173, which codified important flexibilities to modernize the physician self-referral or Stark Law.
- H.R. 4987, which made several key technical corrections to the changes made by MACRA to the physician payment system to provide flexibility to CMS to lower physician burden.
- H.R. 1148, which expanded access to telehealth services for providers serving patients that have suffered a stroke.
- Provisions found in H.R. 2663, which allowed CMS to consider the entire patient's record when deciding if a patient is eligible for home health care services thus ensuring that the patient's condition and status is fully understood while also reducing burden for the home health agency and physician.

As we look to the fall, the Committee will continue to explore common-sense solutions based on the feedback from stakeholders and the Administration. Rulemaking for calendar year 2019 Medicare payments is still under way, and it is crucial that stakeholders understand the importance of the comment period. While Congress and the Committee will submit our thoughts on the proposed and final rules, a consistent and open level of communication on where every stakeholder stands on all of these issues that will reduce burdens and increase value-based patient care is truly important. As such, the Committee will continue to work with the Administration to reduce burden for health care providers looking into 2019 and beyond.