The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

PA HOSPITALS' RED TAPE REDUCTION WISH LIST

September 2017

1. Simplify governmental procedures to reduce red tape and paperwork for hospitals and health systems and other providers

Problem	Solution
Heavy administrative burden for hospitals and health systems due to inappropriate auditing Recovery Audit Contractors (RAC) are paid contingency fees when they reclaim hospital payments. Payment denials are too often based on minor technicalities. Hospitals and health systems often succeed in overturning inappropriate denials, but only after dedicating days of expert legal and administrative staff time investigating and challenging wrongful denials.	**Hold Medicare auditors accountable for poor performance** Revise federal contracts to incorporate financial penalties if RACs' payment denials are too frequently overturned by administrative law judges.
Administrative burden for hospitals and health systems due to complex, obscure Medicare payment processes Current claims review procedures, intended to support program integrity, are creating undue paperwork for hospitals and health systems. Currently, provider claims for services rendered under the "original" (fee-for-service) Medicare program are often denied based on automatic triggers. Hospitals and health systems are given almost no information as to why. As a result, hospitals spend undue amounts of time and resources addressing and, when appropriate, challenging payment denials.	**Make it easier for hospitals and health systems to understand and respond to payment denials** Evaluate payment processes used by commercial insurers (Medicare Administrative Contractors, or MACs) selected to process provider claims for services rendered under the "original" (fee-for-service) Medicare program.

Unnecessary paperwork that's increasing the administrative burden of providing home health care Demographically, the population of the nation, and especially Pennsylvania, is growing older. Home health services are crucial to helping older adults "age in place," improving their quality of life and reducing their health care spending. Several unnecessarily complex Medicare policies and procedures are increasing the administrative burden—and cost—of providing home health care.	**Reconsider and simplify the way providers establish the need for home health services** Streamline the clinical paperwork for demonstrating medical necessity. A supporting diagnosis and related services should be enough. Permanently retire the demonstration project that requires reviews of all home health agency Medicare claims prior to payment.

2. Modernize government policies getting in the way of hospitals' efforts to provide the right care, in the right place, at the right time—with the right patient care team

Problem	Solution
Outdated Anti-kickback and Stark Laws These laws were designed to protect patients' interests under the old "fee-for-service" model of health care delivery and payment. In the new, "value-based" health care model, these laws are holding back the collaboration needed to improve health and health care and tamp down health care spending.	**Create Anti-kickback "safe harbor" and revise Stark Law accordingly** Establish an Anti-kickback safe harbor to: • Support "clinical integration" legal agreements among hospitals and health care providers working to improve care coordination and efficiency • Maintain accountability and safeguard patients' interests Amend Stark Law, creating exception to recognize as legal and appropriate any clinical integration agreements that meet safe harbor requirements.

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Outdated payment policies for telehealth Current regulations severely limit the use of modern communications technology to make efficient use of scarce clinical resources and meet patient demands for convenience and efficiency. Right now, hospitals and other providers are paid only for telehealth services provided to patients who are: • In rural and medically underserved communities • Receiving these services in medical facilities rather than in the comfort of their own homes	**Modernize telehealth payment policies** Revise payment policies in "original" (fee-for-service) Medicare and Medicare Advantage managed care programs to take full advantage of current technology. Expand the ability of patients to get specialized medical care in their own homes and communities!
Payment policies that undermine community care Hospitals and health systems are investing in innovative ways to deliver health care away from the hospital, out in the communities where people live and work. But, Medicare's current outpatient payment policies penalize, rather than support, this trend. Health care services delivered at provider-based hospital outpatient facilities acquired and developed after November 2, 2015, are reimbursed at much, much lower rates than before.	**Rethink payment policies for hospital and health system outpatient services** Revise payment policies to support the delivery of high-quality care in community as well as hospital campus settings.

3. Use quality information effectively and fairly to reward hospitals and health systems for good results

Problem	Solution
Some quality ratings and payments ignore the impact of patients' socioeconomic challenges Patients' socioeconomic factors—like being able to afford healthy food and transportation to and from doctors' offices—can compromise the effectiveness of health care services. But, the formulas used to calculate many Medicare quality ratings and payments overlook the impact of socioeconomic challenges.	**Account for socioeconomic factors in all Medicare quality ratings and payments** CMS is making progress in adjusting some quality-related payments and penalties (such as readmissions penalties) to account for patients' socioeconomic status. Hospitals want to see: Details about exactly how CMS plans to adjust for socioeconomics. The application of socioeconomic adjustments to all appropriate Medicare quality ratings and payments.
Quality payments penalize hospitals for successfully eliminating infections A blip in the current formula for calculating hospital quality incentives actually lowers payments for hospitals that successfully achieve very low infection rates.	**Change volume thresholds in formulas used to reward hospital quality** Lower the minimum benchmark against which hospital infection rates are measured from 1.0 to 0.1 so that hospitals with very low infection rates are rewarded for excellent quality.