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05 28'2002 05:14:07 PM

Record Type: Record

To: John F. Morrall III/OMB/EOP@EOP

cc:
Subject: OIRA request for comments

Attached *is* the American Hospital Association Comment letter of the Draft Report to Congress on the Costs and Benefits of Federal Regulations and Public Nominations of Regulatory Reforms.

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May 28,2002

John D. Graham, Ph.D.
Administrator
Office of Information and Regulatory Affairs
Office of Management and Budget
NEOB, Room 10235
725 17th Street, N.W.
Washington, DC 20503

Via email to jmorrall@omb.eop.gov

RE: Request for Comments of the Draft Report to Congress on the Costs and Benefits of Federal Regulations and Public Nominations of Regulatory Reforms

Dear Administrator Graham:

On behalf of our nearly 5,000 hospital, health care system, network and other provider members, the American Hospital Association (AHA) welcomes the opportunity to provide nominations for reducing the regulatory burden imposed on caregivers by Medicare regulations that may inhibit the delivery of high quality, timely and efficient health care.

Caregivers are frustrated when administrative burdens, driven by complex rules and regulations, shift the focus from patient care to paperwork. Last year, the AHA commissioned PricewaterhouseCoopers to survey hospitals about their paperwork experience. The study, which examined a typical episode of care for a Medicare patient suffering from a broken hip, found that physicians, nurses and other hospital staff spend, on average, at least 30 minutes on paperwork for every hour of patient care provided to a typical Medicare patient. Results also showed that in the emergency department, every hour of patient care generates an hour of paperwork. At a time when hospitals face serious workforce shortages, many caregivers cite regulatory burden as a significant negative aspect of their jobs and a major cause of overtime.

We commend you for your outstanding leadership in the Office of Information and Regulatory Affairs (OIRA) and the proactive approach you have taken to reshape how the federal government regulates business and implements legislation enacted by Congress. Your office's increased scrutiny of proposed regulations and your innovative "prompt letters" to help agencies prioritize the regulatory items on their agendas demonstrates a true "common sense" approach toward regulation.

We would like to take this opportunity to thank you and your staff for your activities and regulatory review of proposals from the Department of Health and Human Services (HHS). Your staffs close scrutiny of several major paperwork requirements currently under review has

encouraged the Centers for Medicare and Medicaid Services (CMS) to closely examine how their proposals place undue burdens on providers and Medicare patients. This work has exposed some systemic problems now being appropriately addressed for the first time in many years.

The AHA has proposed an agenda to address the daily regulatory burdens that hospitals face as they strive to serve their communities' health care needs. These key priorities for regulatory reform are included in Attachment A of this letter. This agenda was submitted earlier this year to HHS Secretary Tommy Thompson and his Advisory Committee on Regulatory Relief. We ask that you, too, consider all 11 points of this agenda as priorities for regulatory reform by this Administration.

We also have urged HHS to consider adopting rulemaking or guidance under the authority granted to it by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to facilitate the prompt and accurate payment of claims. Hospitals' support for administrative simplification under HIPAA was founded on the premise that greater standardization and uniformity of administrative processes will lead to efficiencies and improvements in the timeliness of claims processing and payment, and thus fulfill Congress' objective in enacting HIPAA – reducing the administrative costs of health care.

One of the major administrative costs facing hospitals, and one of their greatest sources of frustration, is frequent delays in the processing and payment of claims. Although Medicare regulations and many state laws have been implemented to try to ensure the prompt payment of claims, these prompt pay rules are often violated or otherwise ignored, particularly by private payers. Hospitals' confidence in, and continued support for, administrative simplification is being eroded by agency statements indicating that providers should not expect to see faster or smoother claims processing and payment as a result of HIPAA standardization.

The HIPAA final regulation on electronic formats and code sets establishes national standards for electronic submission of claims. The regulation clearly states that health plans are not permitted to require additional data elements nor standard data elements in a format different from that specified in the standards. Health plans also may not refuse to accept standard transactions. It seems clear then that a HIPAA-compliant claim is a properly completed claim that is ready for processing and adjudication by a health plan.

We urge that OIRA issue a "prompt letter" to HHS promoting the realization of administrative simplification through the HIPAA regulations and specifically clarify that health plans must accept a HIPAA-compliant claim as a "clean claim" for purposes of contractual provisions with other covered entities under HIPAA, and for state and federal prompt pay requirements. The guidance in Attachment B more clearly explains the role of the trading partner agreement in ensuring that hospitals' adoption of the HIPAA standard formats and code sets ensures acceptance and prompt processing and payment of these standardized claims by all payers. This type of guidance is necessary to address some of the ambiguities in the HIPAA regulation on electronic formats and codes sets. Currently, health plans can be somewhat arbitrary with respect to the processing of a claim, leaving providers facing payment delays and engaging in wasteful re-submissions and reconciliation.

Thank you for the opportunity to share with you some of the regulatory difficulties hospitals face and our suggested solutions. We look forward to working with the Office of Information and Regulatory Affairs and the Department of Health and Human Services to make the Medicare program more workable for patients and providers. Please contact Mary Beth Savary Taylor, vice president, federal relations, at (202) 626-2270 if you have questions or would like further information.

Sincerely,

Rick Pollack
Executive Vice President

Enclosures

Attachment A

The AHA has identified areas where current regulations should be refined and where process reforms are needed to reduce regulatory burden:

I. Streamline the Medicare cost report. **As** you know, Medicare provider payment methodologies have changed significantly since the advent of the program. Prospective payment methods have replaced cost-based reimbursement for hospital inpatient and outpatient care, skilled nursing care, and home health care. Unfortunately, little, if any, information has ever been deleted from the cost report since it was introduced to support cost-based payment. Instead, new requirements have simply been added to support newer payment methods. The present Medicare cost report has outlived its usefulness and should be radically redesigned and simplified.

While it is true that the cost report provides some information currently used to make different Medicare payment determinations, it is considerably more complicated and burdensome than required to collect the needed data to calculate those payments. Furthermore, hospitals maintain accounting records using generally accepted accounting principles (GAAP) for financial reporting, operational decision-making, and external reporting to lenders and the business community. Continued reliance on Medicare-specific cost accounting and allocation principles requires hospitals to adjust their GAAP financial data to the arcane rules required for Medicare reporting. There may not be sufficient value to continue this alternate cost accounting method and, clearly, there is no value in continuing the voluminous cost report that it supports. We refer the Advisory Committee to Addendum **A** of the Cost Report Reform Proposal that the **AHA** sent to Secretary Thompson on October 5,2001.

II. **Revise the HIPAA privacy regulation.** Ensuring the privacy of patients' medical information is a responsibility that America's hospitals have always taken seriously. The medical privacy rule is intended to give patients more control over their personal medical information, and hospitals remain committed to making it work. The Administration has acknowledged repeatedly, however, that the rule is seriously flawed and could, unless repaired, have "negative unintended effects" on patient care and essential hospital operations. The AHA, in its support of meaningful medical privacy standards, has been steadfast in calling upon the Department of Health and Human Services (HHS) to move quickly and decisively to **fix** those portions of the medical privacy rule that threaten patient care and essential hospital operations. The AHA is pleased that the Department has heard this message and responded to many of the concerns that hospitals have raised about the privacy rule by publishing proposed changes in a Notice of Proposed Rulemaking (NPRM) in the *Federal* ***Register*** on March 27,2002. The **AHA** believes that the modifications proposed would improve the workability of the rule for both patients and providers. These changes will allow hospitals to continue to fulfill their commitment to protecting the privacy of their patients' medical information without crippling their ability to provide high quality care to patients and imposing unnecessary paperwork burdens on both patients and hospitals. On April 25,2002, the AHA submitted detailed comments on the changes to the privacy rule proposed by HHS in the NPRM and we have highlighted our comments on several critical issues below.

The AHA strongly encouraged HHS to adopt its proposal to replace the current redundant written consent requirement with written acknowledgment that the patient received the hospital's privacy notice. This change eliminates the barriers to care created by the previous requirement while retaining strong patient protections for non-routine uses of information, such as marketing and research. It also ensures that patients will understand what those protections are and will have ready access to them. Finally, the new requirement assures that time spent in a hospital will be spent on patient care – not filling out unnecessary and redundant paperwork, which is a serious concern for patients and providers alike. In fact, research conducted with more than 900 consumers in April 2002 by an independent research firm, Market Strategies, shows that consumers support elimination of the unnecessary paperwork hassle created by the written consent requirement.

We urged the Department to go farther in a number of areas to build on the considerable improvements it had already proposed. We appreciate and urged adoption of, for example, HHS' clarification that sharing age-specific infomation among hospitals is permitted under the medical privacy rule's de-identification safe harbor. But, we urged the Department to improve upon its proposal by also allowing hospitals to share other non-facially identifiable information, such as zip codes and dates of service, for important purposes such as improving the quality of care for their patients, detecting outbreaks of disease and identifying the need for new and improved community health services. And, although we believe that HHS' suggested compromise that would allow a special limited data set of non-facially identifiable information to be shared among hospitals when accompanied by a data use agreement is not necessary to ensure the proper use of information, it is a significant improvement over the current rule and we urged that it be adopted in the final rule.

We urged HHS to adopt its proposal to extend to April 14,2004 renegotiation of existing business associate agreements to reduce the burdens associated with these requirements and appreciate inclusion of model business associate contract provisions in the proposed modifications. However, HHS should reduce further the complexity and cumbersome nature of the business associate requirements by: (1) eliminating the requirement that covered entities enter into business associate contracts with one another; (2) developing a certification program for suppliers that would eliminate the need for many business associate contracts altogether; and (3) creating an "incidental disclosure" safe harbor that would clearly eliminate concerns that a business associate contract would be needed with organizations where contact with protected information would result inadvertently, if at all (*e.g.*, janitorial services, or from stealth behavior). In addition, HHS should revise the model business associate contract provisions to make them consistent with the requirements of the privacy rule.

We remain concerned about the short deadline for complying with the medical privacy rule and urge HHS to phase it in on a more reasonable schedule. **As** HHS has seemingly acknowledged by extending the compliance date for renegotiating business agreements, many aspects of the medical privacy rule are confusing, burdensome and costly to implement. Some examples include training for all hospital employees and medical staff; developing and implementing policies and procedures to comply with the "minimum necessary" and other restrictions; and

conducting a preemption analysis with regard to state medical privacy laws and integrating the results of that analysis with policies and procedures required by the federal medical privacy rules for one or more states. In addition, the delay in finalizing the security rules has added to the confusion and burden of implementing the medical privacy rule because the two are intertwined. This failure to finalize the security rule further contributes to the need to phase in the privacy rule on a more reasonable schedule.

III. Enable providers to challenge questionable policy actions in **court.** Expedited access to court is essential to provide fundamental fairness for hospitals participating in the Medicare program. In Shalala v. Illinois Council on Long Term Care, the U.S. Supreme Court held that under section 205(h) of the Social Security Act, incorporated into the Medicare Act by section 1872, claims related to the Medicare statute must go through an administrative process before being brought to court. As a result of that decision and the government's expansive application of the holding, providers are being denied the ability to challenge the legality of actions by HHS that, under other agency statutes, would be subject immediately to review.

The problem with the Court's interpretation is that it continues to permit the HHS to rebuff any and all lawsuits against the Secretary for failing to "channel a claim," even when there is no administrative process available. Except for disputes about reimbursement for individual claims (that are clearly appropriate for the channeling requirement), the only time an administrative process is available to hospitals is if they are terminated from the program. The court's decision does not allow health care providers to challenge the Secretary on policy or other grounds. As currently interpreted, the only means for hospitals to challenge an unlawful action by the Secretary is to fail to follow or "violate" the dictates of the Secretary so severely that they are terminated from the program. For example, when HHS issues a regulation that fails to follow the Administrative Procedures Act or is beyond the scope of the Secretary's authority, Illinois Long Term Care precludes a challenge in court, even though there is no administrative means to challenge the Secretary's policy decision. If the Secretary threatens or attempts to hold providers responsible for not meeting a "policy" that should have been and was not issued as a rule, Illinois Long Term Care precludes the provider from seeking relief in court – again, even though there is no administrative means ***to*** challenge the Secretary.

We believe this is fundamentally unfair. **We urge the Advisory Committee to recommend to Congress that the Medicare statute be clarified so that when a dispute, unrelated to the specific situation of a provider or beneficiary, challenges the legality of HHS' actions, or of any of the other grounds for court review that currently exist under the Administrative Procedures Act, a hospital or other provider is entitled to bring an action in court.**

IV. Prohibit the denial of payment by Fiscal Intermediaries (FI) for emergency services provided to Medicare beneficiaries that are required by the Emergency Medical Treatment and Active Labor Act (EMTALA.) As a participating provider in the Medicare program, a hospital is required to screen any individual who comes to the emergency department, determine whether that person has an emergency medical condition or is a woman in active labor and, if so, to stabilize him or her, as mandated by EMTALA. To adequately screen and stabilize the

patient, we are required to employ ancillary services routinely available to the emergency department.

Medicare sometimes denies payment for the services furnished in emergency departments because they exceed the local medical review policies (LMRPs) or utilization guidelines for coverage and frequency established by the local Medicare fiscal intermediaries (FIs). However, hospitals are prohibited from billing beneficiaries for such services unless we notify patients in advance that the service may not be covered, using an advanced beneficiary notice. Conversely, we cannot notify patients in advance because the Inspector General interprets this advance notification of possible non-coverage as a delay in screening and stabilization. Hospitals, caught in a "Catch-22," are often left with an unpaid bill for emergency care. The solution is simple: If hospitals must provide the services, Medicare should pay. We refer the Advisory Committee to Addendum B of an AHA letter sent on September 21,2001 to CMS Administrator Tom Scully. In the letter, **we detailed additional EMTALA reform issues, including establishing an EMTALA Advisory Committee; allowing for Administrator-level review of a Regional Office's determination prior to issuing public notice of a hospital's termination from the Medicare Program; and ensuring that EMTALA does not apply beyond the emergency room.**

V. Further Streamline the Medicare Secondary Payer Provision. We are pleased that CMS has taken a first step in reducing the burdensome requirement that patients fill out the 25-question Medicare Secondary Payer (MSP) questionnaire every time they come to the hospital for recumng services, such as chemotherapy or blood work. The MSP is intended to identify other insurance coverage a beneficiary might have. CMS has proposed that the questionnaire be completed every 30 days for a recurring therapy and every 60 days in the case of a non-patient (where the hospital has no contact with the patient and only receives a specimen from the patient's doctor.) **Altering this to require completion of the MSP every 90 days for recurring services instead of every 30 days would be more than sufficient to capture changes in a Medicare beneficiary's insurance status and would be consistent with the comments Secretary Thompson made at the AHA's annual meeting** in **April 2001.**

Regarding the 60-day requirement for completing the MSP form when hospitals have no direct contact with the patient and are simply being used as a reference lab, hospitals should not be responsible for collecting the MSP information for these patients, just as independent labs performing the same services are not responsible for securing this information.

In addition to these issues, we request that the Advisory Committee consider the following regulatory changes:

VI. Limit data collection to what is necessary for payment and quality. Prospective payment systems should be simple, predictable and fair. Unfortunately, the patient assessment tools for skilled nursing, rehabilitation and home health have been far from ideal. In fact, CMS devised three separate instruments, OASIS, MDS, and MDS-PAC, which have collected much extraneous information, have lacked statistical reliability, and are extremely burdensome. Recognizing the immediate need for reforms in this area, Secretary Thompson and Administrator

Scully shelved the MDS-PAC for inpatient rehabilitation facilities, eliminated the MDS requirement for critical access hospital swing beds and significantly streamlined the MDS for non-critical access hospital swing beds. We commend them for these important changes. In the meantime, hospital-based skilled nursing facilities still need relief from the MDS and home health agencies need relief from the excessive burdens and often-irrelevant information requirements imposed by the OASIS assessment tool, which has close to 100 questions and takes roughly 90 minutes to complete on each new patient. We urge the Advisory Committee to review the specific recommendations we made to Secretary Thompson on streamlining the OASIS form as noted in Addendum C of our July 10,2001 letter followed by the AHA's September 24,2001 letter to Secretary Thompson focusing on MDS reforms.

VII. Coordinate the orderly release of federal regulations to allow for more seamless compliance. Government agencies with jurisdiction over hospitals need to release regulations in a coordinated manner so that implementation does not overwhelm hospital personnel and systems. That means establishing a point of accountability to coordinate regulatory activity across major federal agencies, as well as within HHS. As the predominant federal regulator of hospitals, HHS should periodically evaluate the total effect of regulations applied to health care providers for clarity and consistency regarding expected provider behaviors. As part of this evaluation, we are pleased that Secretary Thompson has ordered a top-down review of all HHS regulations to determine whether they are confusing, conflicting, impose unnecessary costs or penalties, or are simply burdensome.

VIII. Provide interpretive and advisory guidance on Medicare payment requirements. Medicare requirements for provider participation and payment are increasingly voluminous and complex, making compliance difficult, while penalties for compliance failures are increasingly severe. We recommend to the Advisory Committee that CMS establish query mechanisms for individual providers and their associations on the appropriate interpretation or application of Medicare rules in specific situations. CMS' responses should be timely and readily available to others in an easily accessible format, such as an indexed file on the Internet.

IX. Seek greater provider input on new rules and regulations; assess patient impact. We are pleased that the Secretary has taken an active role in seeking greater input from provider groups on rules and regulations. Federal regulators need to become more acquainted with real-world hospital operating environments so that practical implementation issues can be minimized before a regulation goes into place. We support Secretary Thompson's recommendation that CMS pilot test new regulations before requiring implementation nationwide. CMS and the Food and Drug Administration (FDA) should solicit early input from the health care field, and should publish notices of intent; make relevant databases, cost estimates, assumptions, and methodologies publicly available early on; hold field hearings; and conduct site visits. There are significant differences among America's hospitals in their size, complexity and available financial and human resources. Despite their obvious differences in size and roles, a 25-bed rural critical access hospital, a 200-bed community hospital, and a 500-bed teaching hospital all must meet the same requirements in the same way. We urge the Advisory Committee and CMS to test constantly for flexibility in compliance approaches. A "one size fits all" approach is inherently unfair and hits hardest those least able to hire the additional

specialized personnel or expensive consultants needed to respond to the latest regulatory initiatives.

X. Restrict use of interim final rules. CMS has increasingly issued new rules as interim final rules; that is, issued and implemented before the agency takes public comment. To reduce the disadvantages of this approach – which negates the public comment process – CMS should limit its use of interim rules and, when used, issue final rules within a year to ensure that public comments are taken into account on a timely basis.

XI. Republish the 1997 Medicare Hospital Conditions of Participation for comment. The 1985 Hospital Medicare Conditions of Participation (COP) were revised and published as a proposed rule in the December 1997 Federal Register. Since that time, sections of the COPs have been published as final or interim final rules, such as the patient rights standards and organ procurement standards. However, the bulk of the standards have yet to be finalized. While we have a keen interest in updating the remaining proposed standards, the last five years have been marked by considerable advancement in health services research and the science of quality assurance and improvement. **As** a result, it is vital that CMS revisit the Medicare COPs and publish the remaining standards as a proposed rule with a 60-day comment period. To simply finalize the 1997 proposal, or to continue to apply the 1985 standards (the last time that the COP was published) is not an acceptable position. **In addition, any disparities between Medicare COP standards and JCAHO standards should be addressed by CMS, as these incongruencies render accredited hospitals in the untenable position of "serving two masters."**

Attachment B

Prompt Processing and Payment of HIPAA Standard Electronic Claims
The Need for Additional Guidance to Improve HIPAA's Standard Formats and Code Sets Rule

Introduction

In establishing the requirement for standard formats and code sets for electronic transactions, Congress stated that it intended the standards to achieve "the goals of improving the operation of the health care system and reducing administrative costs." However, there are ambiguities in the transactions and code sets regulations that, without clarification from HHS, threaten to make it impossible for these standards to achieve their fundamental purpose. More precisely, the statute says the standards are fixed and in effect for a full year; but, without further guidance, every health plan selectively may modify what is regarded as a clean, standard transaction at any time and the plan can do so as many times in a plan year as it chooses. Following is a brief explanation of the ambiguities in the regulation that create this problem and a proposal for guidance that would resolve the ambiguities and ensure that Congress' intent is implemented and its goals achieved.

Ambiguities in Transactions and Code Sets Rule and Obstacles to Prompt Claims Processing and Payment

Despite the significant investment of financial and staff resources that will be needed to implement the requirements of the transactions and code sets regulation, hospitals generally support standardization. It is their hope that once formats are standardized, it will be possible to accurately submit claims that payers can process promptly. Hospitals currently incur significant financial losses fiom the delay in processing claims or the rejection of claims as "incomplete" on initial submission. Congress established the "administrativesimplification" requirements o f HTPAA in recognition of the fact that standard formats and code sets offer the possibility of eliminating the waste of resources from the denial, resubmission, and delay in processing claims by making it possible for a provider to efficiently submit "clean" claims to multiple health plans.

HHS attempted to achieve Congress' goals by promulgating the new standards and establishing the following new regulation: "A health plan may not reject a standard transaction on the basis that it contains data elements not needed or used by the health plan (for example, coordination of benefits information)." 45 C.F.R. §162.925(a)(3). This rule will help eliminate frivolous denials that result fiom the intolerance of information processing programs.

For each of eight national transactions specified by Congress in the HIPAA statute, the transactions and code sets regulations define a "standard" transaction as:

- Using the right electronic format;
- Using the right medical code sets, including all of the "required" elements for the particular transaction; and

- Including no elements that are not specified in the Implementation Guide as permissible "situational" elements for the particular transaction.

In order for a provider to submit a transaction in standard form, however, the health plan to which it is sending the transaction must specify which of the optional "situational" elements for the transaction is necessary to process the transaction. (The total possible pool of situational elements for each transaction is specified in the Implementation Guide.)

There is ambiguity in the regulation because it does not ***require*** health plans to inform providers *which* of the optional situational elements will be necessary for a clean, standard transaction. Instead, the regulation merely tells plans that they cannot agree to circumvent the standards or use elements that exceed the maximum data set in a trading partner agreement. The regulation specifically prohibits covered entities from participating in certain kinds of arrangements that would circumvent Congress' intent that there be clear, standard formats for common administrative transactions, 45 C.F.R. § 162.915. The rule explicitly states:

> "A covered entity must not enter into a trading partner agreement that would do any of the following:
>
> a) Change the definition, data condition, or use of a data element or segment in a standard.
>
> b) Add any data elements or segments to the maximum defined data set.
>
> c) Use any code or data elements that are either marked 'not used' in the standard's implementation specification or are not in the standard's implementation specification(s).
>
> d) Change the meaning or intent of the standard's implementation specification(s)."

The regulation is unclear as to whether a health plan can arbitrarily change its specifications regarding which situational elements are necessary for processing a claim of a particular type, thus further delaying payment.

Under the privacy regulation, the provider is required to send only the minimum information necessary for the purpose, but the provider cannot anticipate what is required if the health plan has not specified which situational elements it deems necessary, 45 C.F.R. § 164.514(d). In effect, without specification from the health plan, providers — after significant investments to reprogram information systems to use the new standards — are in the same position as before. If health plans are free to be somewhat arbitrary with respect to the elements necessary for processing a given transaction, or to reject claims of certain types if they do not routinely include an attachment, providers still will be faced with payment delays, frivolous rejections of claims, and the need for wasteful re-submissions and reconciliation. This is not consistent with Congress' intent. Moreover, it seems clear from the rule that HHS did not intend this result.

Proposed Guidance

It is clear that the regulation anticipates that each health plan will promptly inform providers of any special situational elements the plan may require for prompt processing of a standard

transaction, and that these selections should be relatively predictable. Otherwise, it would make no sense to pretend that the regulation has established a "standard" form for the transaction. Accordingly, HHS should promulgate guidance that more clearly explains the role of the trading partner agreement in ensuring that the industry's expenditures to adopt the formats and code sets actually achieves Congress' objectives. Following is a suggestion of the type of guidance necessary to address the current ambiguity.

"Trading Partner Agreement" **45** C.F.R. § 160.103.

A trading partner agreement is the primary vehicle by which a health plan specifies which of the situational elements permissible for a standard transaction will be needed for prompt processing of the transaction under the health benefits plan. At the option of the health plan, a trading partner agreement may be uniform for all health benefits programs administered by the health plan.

1. A health plan may modify a trading partner agreement to change specifications for a standard transaction only to accommodate (i) a duly promulgated change in the standard, or (ii) a lawful modification of a health benefits plan available to enrollees and/or beneficiaries.

2. With respect to a health plan that fails to promulgate a trading partner agreement applicable to a health benefits package, a transaction is deemed to meet the requirements of this part if it includes the maximum defined data set for a standard transaction.

A health claim that meets the requirements of this part and any trading partner agreement applicable to the beneficiary's health benefits plan shall be considered a "clean claim" for purposes of state and federal laws and regulations applicable to the processing of such transactions.

Addendum A

October 5,2001

The Honorable Tommy G. Thompson
Secretary of Health and Human Services
200 Independence Avenue, SW
*6*15F Hubert H. Humphrey Building
Washington, DC 20201

Dear Secretary Thompson:

The American Hospital Association (AHA), on behalf of its nearly 5,000 hospitals, health systems, networks and other health care providers, commends you for your continued efforts to reduce unnecessary paperwork burdens in the Medicare program. We are very supportive of your recent statements about reforming the cost report, particularly your intention to eliminate the separation of capital into old and new capital, and the separate Provider Questionnaire Form 339.

Because of our membership's longstanding concerns with the existing cost report, the AHA began earlier this year to develop new approaches for collecting hospital and financial data in the most efficient manner. We sought input from representatives of hospitals and health systems -- large and small, rural and urban, for-profit and not-for-profit. The enclosed paper proposes an overhaul of the cost report that will reduce the cost reporting burden for both hospitals and the Medicare program, without jeopardizing the collection of necessary data for federal policy makers. We propose shifting the emphasis of the data collection away from determining allowable cost-based reimbursement, to that of providing for an accurate financial representation in a uniform manner. To achieve this goal, we believe that a cooperative effort involving the Department of Health and Human Services, hospitals, fiscal intermediaries, and data user representatives would be a productive approach.

We look forward to working with you and Centers for Medicare and Medicaid Services Administrator Tom Scully to re-examine the cost report.

Sincerely,

Rick Pollack
Executive Vice President

Attachment

cc: Tom Scully, Administrator, CMS

Attachment

ISSUE PAPER
REDUCING THE COST REPORT BURDEN

OBJECTIVE:

Over the last few years, the federal government has been implementing health care pay-ment policy changes that limit their payment responsibilities for services provided by hospitals to Medicare beneficiaries. No longer does the federal government believe it is obligated to reimburse hospitals for the cost of the care that is being provided, either on a service-by-service, hospital-by-hospital, or beneficiary-by-beneficiary basis. While there has been this change in policy, the Medicare program has not changed its administrative practices that were adopted during the time in which payments were made based upon the cost of the services being provided, in particular the cost reporting requirements and practices.

Under cost reimbursement, Medicare specific laws and regulations were adopted that enabled the Medicare program to identify and determine the costs of the services that were being provided to the Medicare beneficiaries. The purpose of these rules was to ensure that the Medicare program would only pay for the reasonable costs of these services, and that they were only paying for services provided to Medicare beneficiaries. In order to accomplish this objective, cost reporting rules were implemented that established the practices for capturing reasonable costs specific to the Medicare program. These included rules for determining costs on a departmental basis, allocating overhead costs to patient care departments (cost finding), allocating costs based upon the ratio of Medicare charges to total charges (prohibiting cost shifting between payers), and establishing cost limits on specified services. This detailed reporting to the Medicare program through the cost report was essential in determining Medicare's share of costs for which it was responsible.

As a result of Medicare payment policy changes, such detailed reporting no longer serves the original purpose of determining Medicare costs for reimbursement purposes. Comparisons cannot be made between costs determined under a cost reimbursement system and actual hospital costs incurred under a prospective payment system. Behavioral incentives under each system are not consistent. Continuing to require the same detailed level of reporting under **a** prospective payment system as that required under a cost reimbursement system results in excessive burdens being placed on both the government and the hospitals that are required to provide such reporting, without a clear purpose for such an activity.

The objective of this issue paper is to identify approaches for collecting hospital financial and utilization data in the most efficient manner to meet the needs of the Medicare pro-gram and federal policy makers as reimbursement methodologies continue to be recon-figured. The goal is to ease the burden placed upon hospitals in providing the required information. This may be done by simplifying the data collection worksheets (Medicare cost reporting forms) and supporting documentation, as well as eliminating the many obstacles that burden hospitals in attempting to comply with standards and requirements being imposed by the Centers for Medicare & Medicaid (CMS-formerly known as the Health Care Financing Administration or HCFA).

APPROACH:

In order to identify the specific data, collection and process issues that hospitals would like to see reevaluated in light of the new reimbursement methodologies being applied by the Medicare program, the American Hospital Association solicited input from numerous hospital representatives. These included financial specialists from a number of the hospital associations, from health care systems, and from a number of rural hospitals. These groups provided a representative cross section of individuals that were very familiar with the current data submission requirements from the Medicare program (Medicare cost re-ports) and the new reimbursement methodologies.

The overall consensus of these groups was that the current cost reporting requirements, from the type of data being collected to the processing of the data, are burdensome, inefficient, counterproductive and not consistent with the new reimbursement methodologies. In the next year or two, with the exception of critical access hospitals, cost-based reimbursement virtually will no longer exist. In the near future, prospective payment systems will be in place for all inpatient acute care services, skilled nursing services, home health agencies, rehabilitation hospitals and units, psychiatric hospitals and units, long-term care hospitals, and outpatient services. Improvements can be made that will ease the cost re-porting burden, both upon the hospitals and the Medicare program, without jeopardizing the collection of necessary data for federal policy makers by shifting the emphasis of the data collection away from determining allowable cost-based reimbursement to that of providing for an accurate financial representation in a uniform manner.

The basic approach would be to examine the current cost reporting forms, along with the related instructions and manual provisions, to only provide useful and meaningful data. The examination would start with the premise that the current cost report should be discarded. It should also be done in a manner that will be consistent with hospital accounting and reporting practices. For example, if a hospital is not going to receive reimbursement based on "reasonable" costs, then the data should not be submitted under a "reason-able" cost methodology, but should be consistent with generally accepted accounting principles (GAAP). This would provide a more accurate representation of a hospital's actual financial condition, allowing federal policy makers to make decisions based upon the actual revenues earned and costs incurred by the hospital. In addition, there is no purpose in requiring the submission of significant support data, or even the audit of this information if there is not a reimbursement impact. Virtually every hospital or health system has a year-end audit by an independent CPA. This should assure that the financial information is free of material misstatement and is presented in conformity with GAAP.

The basic premise behind this evaluation of the data reporting process should be to eliminate the concept of cost reporting and be based upon determining the data needs to sup-port policy analysis. To accomplish this objective, a process should be established that takes the following actions:

- Eliminate the current cost report and cost reporting concepts.
- Develop a new report that is based upon Generally Accepted Accounting Principles.

- Determine the data requirements for this report that will consider the needs of government policy makers, hospitals and hospital advocates.

- Seek simplicity in terms of both the collection of data elements and the data reporting itself.

- Rename the report to reflect its purpose, e.g. Medicare Data Report.

It should be noted that any significant changes to the data reporting process might disrupt the ability to analyze data over consecutive periods of time. The loss of trend analysis needs to be measured against the potential reductions in reporting burdens. However, if the reporting requirements are simplified, data users might be able to modify some past years' already reported data into a similar simplified version in order to allow for some trend analysis. After a few years this would become a moot point.

This issue paper will outline a specific approach, based upon the input and recommendations of the hospital representatives identified above. The recommendations all relate to one of three categories, which are as follows:

- Simplify the cost report worksheets and requirements

- Evaluate the purpose of the CMS Form 339 and related data requirements

- Improve the efficiencies of the cost reporting processes

Although it will be important to determine the appropriate vehicle for making these changes, we believe that most of the recommendations can be made at the administrative level, without the need for a regulatory or legislative change. However, there does need to be a determination prior to initiating this evaluation and modification of the reporting process of who at CMS has the authority to proceed with the recommended changes, to ensure the effort is constructive.

SIMPLIFY THE COST REPORT WORKSHEETS AND REOUIREMENTS:

Recommendations:

1. Generally Accepted Accounting Principles (GAAP) cost reporting should replace Medicare regulatory cost reporting.

2. Cost report worksheets and data reporting requirements should be simplified.

3. Medicare's Provider Reimbursement Manual (PRM) and other cost report related instructions should be rewritten to be consistent with the new simplified cost reporting requirements.

Discussion:
Adopting a reporting system based upon GAAP would eliminate the need for burden-some detailed regulations and instructions, as well as duplicate reporting. If GAAP were the reporting basis instead of the current cost-based regulations, the cost report would provide a more accurate representation of a hospital's financial information. The first step in defining the data reporting

needs would be to determine the relevant data from the cost report that is currently being used and for what purpose. Then develop a new cost report based upon GAAP to achieve consistent reporting based upon currently accepted standards, as opposed to modifying the current cost report. The new cost report work-sheets could also include other necessary Medicare data elements as appropriate. For example, if the policy makers want to measure hospital profitability, it would be more accurate to compare a hospital's actual costs, not allowable costs, with the reimbursement they are receiving. Since cost-based reimbursement is being replaced by prospective payments systems, the need for much of the detailed data is already being eliminated. With GAAP reporting, the accuracy and timeliness of data will be improved.

Specific Revisions:

- Eliminate all cost report worksheets or components of cost report worksheets that are based upon cost reimbursement principles, or no longer serve any purpose. These would include reclassification of expenses, disallowances of expenses, establishment of non-reimbursable cost centers, separation of capital costs by "old" and "new" capital, and elimination of all non-prospective payment "settlement" worksheets. For ex-ample, worksheets related to hospital outpatient "blended" reimbursement (cost plus fee schedule) or End Stage Renal Disease appear to have little usefulness. In addition, eliminate other hospital reports and reporting requirements beyond the hospital cost report that would no longer be necessary. One example would be the Home Office cost report.

- Simplify the cost report worksheets or components of cost report worksheets to re-duce complexities in data gathering. This would include a more streamlined process for allocating overhead costs to revenue producing departments, reducing the number of cost centers being reported by combining common services, and limiting financial statement reporting to the Balance Sheet and Income Statement.

- When simplifying the reporting process issues it will be important to thoroughly ex-amine current reporting requirements that should not be modified or eliminated. **As** part of the determination of data needs, information that is necessary for current re-imbursement purposes needs to be collected, or the reimbursement methodologies need to be modified. This would include data related to GME, IME, DSH and PIP payments.

- Improving the reporting process also needs to be considered along with simplification. For example, the new data report should provide a better matching of cost centers with revenue codes used for billing Medicare. It may be appropriate to allow hospitals to report data in broader cost centers, even if they are currently reporting at a more detailed level. For example, if a hospital is reporting expenses for MRI, C-T Scan and Radiology, they should have the flexibility to combine these departments and report them all as Radiology. From a data user standpoint the new report might want to provide financial statements that are consistent with both the terminology and data elements that are utilized by financial institutions, such as those institutions that establish bond rankings.

- Allow critical access hospitals, and any other hospitals that may have cost-based reimbursement (e.g., cancer hospitals and children's hospitals) the same simplification process as prospective payment hospitals since these will represent a small minority of the total number of hospitals. The hospital reporting requirements should not be determined based upon the few hospitals that remain under cost-based reimbursement. However, these cost-based hospitals could be provided with some additional schedules in order to achieve an appropriate settlement.

- Medicaid programs in various states that utilize the current Medicare cost reporting forms for their reimbursement programs will have to establish their own reporting forms and will no longer be able to rely on Medicare for these worksheets. However, it should be noted that as Medicare has modified its cost reporting forms in the past, the Medicaid programs have been able to adapt. However, their concerns or issues should be taken into consideration.

EVALUATE THE PURPOSE OF THE CMS FORM 339 (PROVIDER QUESTION-NAIRE) AND RELATED DATA REQUIREMENTS:

Recommendations:

1. The CMS Form 339 Provider Questionnaire should be evaluated to determine if it should be eliminated.

Discussion:

CMS should determine the purpose of having hospitals complete the provider question-naire (CMS Form 339) under a prospective payment system methodology. Instead of requiring a separate document, CMS could restructure any necessary questions as "yes" or "no" questions and include them as a worksheet on the revised cost report, or as part of the current cost report worksheet S-2. The only data currently reported on the questionnaire that is relevant to the prospective payment system relates to fringe benefits that are utilized in calculating the area wage index. This data could be added to the current cost report worksheet **S-3** wage index information. The fiscal intermediary or CMS could re-quest any other pertinent documentation on an as needed basis, instead of at time of filing. Making "hard" copies of numerous documents, such as contracts, is very time consuming and burdensome, and does not serve any purpose under a prospective payment system.

Specific Revisions:

- Eliminate the CMS Form 339 simultaneously with the implementation of the simplified Medicare cost report.

- Any questions or data needs that are still relevant to the current CMS Form 339 under a prospective payment system should occur after completing the evaluation of the Medicare cost report worksheets and incorporated as appropriate.

IMPROVE THE EFFICIENCIES OF THE COST REPORTING PROCESSES:

Recommendations:

1. Efficiencies gained through the electronic submission of the cost report should be used to attain more accurate and timely information, as opposed to being used as a hindrance to the process.

2. CMS should evaluate its current administrative functions that are being employed in a cost reporting setting and consider expending resources only in areas that will impact the integrity of the data that is being reported.

Discussion:

The Medicare cost report electronic reporting requirements are found in Medicare regulations. Neither the Medicare regulations nor the preamble to those regulations published in the ***Federal Register*** establish objectives or reasons for requiring electronic reporting. It is fairly obvious that the primary objective was to make the system more efficient. Be-fore electronic reporting, fiscal intermediaries had to key enter in all the data from "hard copy" Medicare cost reports. By reducing the time needed to produce a usable data file, the fiscal intermediaries have more flexibility in applying resources. This also contributes to a more efficient cost report process.

There are many reasons the current system does not work as well as it could. The system is incredibly complex. There are many entities involved, including hospitals, fiscal intermediaries and CMS. Each entity has its own perspective, responsibilities and incentives. Each entity has limited resources and conflicting priorities. The system is also plagued by the most common communications problem: the parties are not listening to each other.

The process of accepting and rejecting cost reports has characteristics that are unfair to hospitals. **A** provider is put in a position where it has no control over which edit checks will cause the cost report to be rejected and all of the responsibility for passing these edit checks before the cost report will be accepted. CMS has allowed fiscal intermediaries to reject hospital submitted cost reports even when they have passed all of the edit checks on a CMS approved cost report software program that was to have included all possible edits that could result in a cost report rejection. These rejections not only have a negative impact upon a hospital's cash flow, but also have a negative impact upon CMS's ability to achieve the efficiencies in processing and distributing timely information. Under prospective payment systems, along with a completely electronic reporting system, it is counterproductive to reject filed Medicare cost reports. Corrections to edit problems can easily be made through telephone contact or e-mail, thereby allowing the fiscal intermediaries to continue to process the cost reports without nonproductive and unnecessary de-lays.

The submission of "hard copy" data is also inefficient under a prospective payment sys-tem. The purpose of "hard copy" data is to validate the information that is being reported in electronic format. Under a prospective payment system there are no incentives to intentionally report data

inappropriately. This minimizes the need for a costly and time-consuming validation process, which can be replaced with more efficient electronic editing process to identify and correct data errors. Therefore, "hard copy" information, such as cost report workpaper support, "reserve" cost reports, "interim" cost reports, and other such data, serve no purpose other than to burden hospitals and fiscal intermediaries with collecting, reviewing and storing useless paper.

The evaluation of other CMS administrative processes and requirements should also be analyzed under a prospective payment system. The need to continue auditing cost report information where incentives do not exist to provide incorrect information would be an inefficient use of government resources. If the Medicare cost report is based upon **GAAP,** then the data will typically be audited by independent CPAs to ensure its accuracy. In addition, the role and function of the Medicare cost report appeals process will need to change, the need to create PS&R (payment summaries) in their current detailed formats may not be relevant, the role and functions of the fiscal intermediaries may be able to be lessened, and many other administrative functions could be either eliminated or greatly reduced. All of these changes will significantly reduce the costs to administer the Medicare cost reporting function without jeopardizing the quality of the data being reported.

Specific Revisions:

- Identify all administrative processes and functions that currently impact the Medicare cost reporting function.

- Evaluate their purpose and specific functions under a cost-based reimbursement sys-tem versus a prospective payment system.

- Determine which functions could be changed or eliminated in order to obtain efficiencies under a prospective payment system. Identify the cost versus the benefits of such recommendations in terms of impact on hospitals, fiscal intermediaries and CMS.

- Seek implementation of these process improvements simultaneously with the recommendations related to the Medicare cost report simplification.

Addendum B

September 21,2001

Thomas Scully
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 443-G
Washington, D.C. 20201

Dear Tom:

It was good to see you Wednesday. We had a great exchange on many of the issues of importance to hospitals. In light of the length of the meeting, there were only a few minutes to talk about EMTALA. Wanted to drop you a note with some additional thoughts.

Hospitals take their EMTALA responsibilities very seriously. They agree with and support the purpose of EMTALA, to ensure that people who need emergency services get them. We appreciate the commitment you and Secretary Thompson have made to reexamine the EMTALA regulations. As you do so, we'd like to suggest you take a look at the following recommendations. They are intended to help hospitals meet their responsibilities, consistent with the original intent of the statute.

Establishing an EMTALA Advisory Committee

An EMTALA Advisory Committee should be established to allow national stakeholder organizations to seek and obtain reliable guidance from the Centers for Medicare and Medicaid Services (CMS) Central Office. The committee also would serve as a forum for CMS to solicit input on policy matters the agency may be considering. The creation of such a committee is consistent with comments CMS officials made in a recent General Accounting Office (GAO) report. Until the committee is in place, CMS should issue no further guidance or regulations related to EMTALA.

Rationale: Ensuring compliance with EMTALA is an enormously complex and important responsibility for hospitals. The penalties for violations can be severe, including termination from Medicare and Medicaid and significant civil monetary penalties. Further, as the health care environment changes, questions about EMTALA continue to arise. Hospitals seeking answers often turn to their CMS regional office for answers, as well as to consultants who purport to know the intent of CMS and the HHS Inspector General on these matters. Unfortunately, different regional offices may provide contradictory answers to common questions and consultants often base their advice on incorrect or misinterpreted information. A process should be created to provide reliable national guidance with input from all stakeholders with an interest in making EMTALA work.

Administrator-Level Review: Recourse for Providers under EMTALA

Create due process for hospitals by providing for Administrator-level review of a Regional Office's (RO) determination, before it issues public notice of termination and sends the termination letter.

Rationale: Under current enforcement policy for EMTALA, a hospital under investigation cannot make a reasonable challenge to a CMS RO finding that the hospital did not comply with the law. Under the routinely used "fast track," a hospital is notified that it has been found out of compliance and will be terminated from the Medicare program in 23 days unless it develops a plan of correction that is acceptable to the RO. Under such severe time restraints, no hospital can risk termination by trying to convince its regional CMS office that there was not a violation of EMTALA. In addition, such a challenge would potentially alienate the RO staff who accept or reject a plan of correction.

EMTALA Does Not Apply to Inpatients

EMTALA should not be applied to inpatients. Patients admitted through the emergency department and patients admitted on a scheduled basis have, by virtue of admission, access to emergency services as needed. During the oral argument before the Supreme Court in 1998 in the Galen v. Roberts EMTALA case, the Solicitor General represented that the Secretary intended to issue a regulation on the application of EMTALA to inpatients. It is our understanding that a proposed regulation was in-process and called back for review based on the January 20,2001 Andrew Card memo.

Rationale: Congress enacted EMTALA to ensure that people have access to emergency services without regard to their ability to pay. Once a person is admitted as an inpatient, the hospital has taken responsibility for more than is required under EMTALA. At that point, the usual hospital-patient and doctor-patient relationships exist, creating duties of care for the hospital and physician, and giving patients legal recourse if those duties aren't met. To apply EMTALA to inpatients means subjecting the more than 32 million discharges and transfers annually to EMTALA transfer requirements (explanation of risks and benefits of transfer, patient consent, etc.) although CMS and many other health plans already offer ample opportunity for patients to question whether they should be discharged or transferred to a post-acute setting. It also creates a significant burden of keeping all hospital staff current on EMTALA (not just the statute and formal requirements, but the continually evolving informal guidance). We have not seen any evidence that hospitals are admitting patients as inpatients in order to circumvent their screening and stabilization obligations under EMTALA.

Local medical review policies (LMRP) should exclude services provided in the ED

Services provided in the emergency department (ED) to meet obligations under EMTALA should be excluded from local medical review policies (LMRPs).

Rationale: Fiscal Intermediaries (FIs) and carriers develop local medical review policies to more effectively control utilization of services. However, when patients come to the ED, hospitals are obligated to provide all of the services that physicians order to screen and stabilize patients who may have an emergency medical condition. Payment for these services is often retroactively denied on the basis of LMRPs. Because hospitals are obligated by EMTALA to provide

screening and stabilization services, CMS should ensure that FIs specifically omit ED services from LMRPs. We would be happy to provide you with examples of these kinds of LMW-related denials in the ED.

We appreciate your consideration of our recommendations. And, again, we appreciated the opportunity to meet with you, and we look forward to continuing to work together on this and other issues so important to the care of the patients we serve.

Sincerely,

Rick Pollack
Executive Vice President

Addendum C

July 10,2001

The Honorable Tommy G. Thompson
Secretary of Health and Human Services
200 Independence Avenue, SW
615F Hubert H. Humphrey Building
Washington, DC 20201

Dear Secretary Thompson:

The American Hospital Association (AHA) welcomed your recent announcement of a regulatory relief initiative aimed at freeing caregivers from burdensome paperwork so they can focus their energies on direct patient care. We have responded on several occasions already to your invitation to offer solutions to the paperwork burden. Most recently, you requested recommendations from the AHA on streamlining the paperwork encountered by home health agencies, specifically the Outcome Assessment and Information Set (OASIS).

In addition to representing nearly 5,000 hospitals, AHA represents approximately 2,400 hospital-based home health agencies, accounting for one-third of Medicare program payments and about 40 percent of beneficiaries who use Medicare-covered home health care annually. The AHA also represents other forms of post-acute care, including approximately 1,500 hospitals with "swing beds," over 2,000 skilled nursing facilities, nearly 1,000 inpatient rehabilitation units/facilities, and 300 long-term care hospitals.

While we support the collection of information necessary for accurate Medicare payment and program oversight, **we find the overall frequency and scope of patient assessment forms required by the Medicare program to be unduly burdensome, lacking justification and duplicative of data collected by other means.**

Consistent with your June 8,2001 request to provide concerns, but also to provide solutions, attached is an AHA proposal to reduce the administrative burden associated with home health patient assessment forms. We have suggested changes to reduce the amount and frequency of information required to be collected, while maintaining the ability to generate necessary information for patient care. Indeed, the number of "items" in our proposal is one-third the number required in the existing assessment form.

We have also taken the liberty of including a proposal to streamline the Minimum Data Set (MDS) for skilled nursing facilities and hospitals with swing beds. This proposal includes suggested changes that reduce the amount of information collected by providers in short periods of time and provides a payment option for hospitals that relies on a less data-intensive methodology. Our concerns about the MDS as it is used in the Medicare SNF PPS parallel those of the Medicare Payment Advisory Commission's (MedPAC) March, 2001 Report to Congress on Medicare Payment Policy. MedPAC's concerns include the appropriateness of the MDS in measuring the intensive care needs of post-acute patients.

These proposals build upon the recent decision by the Centers for Medicare & Medicaid Services (CMS) to significantly streamline the patient assessment form originally proposed for use in Medicare payment to inpatient rehabilitation facilities. The AHA proposals are designed to reduce administrative burden while preserving our mutual goals of providing high-quality, cost-effective care to the elderly and disabled.

Complete records and documentation are necessary for patient safety and quality care. But complying with the numerous regulations issued by CMS and other federal, state and local regulatory agencies should not dominate a caregiver's day, nor should it unduly intrude on a patient's time and privacy. While some paperwork is necessary for clinical purposes, there has been a significant increase in government-mandated paperwork, with inflexible requirements that add little or no value to the care being delivered, and may actually diminish it. Moreover, the sheer length and frequency of the Medicare-required forms undermine the reliability of all of the data being collected, further reducing the value of the patient assessment process. Our vision of the future includes the notion that *streamlined* administrative processes can lead to *more* reliable information, leading in turn to more accurate and meaningful assessments of quality.

Thank you for the opportunity to work with you to achieve sensible solutions. We look forward to helping you implement these recommendations. If you have any questions, please contact me or Brian Ellsworth at (202) 626-2320.

Sincerely,

Rick Pollack
Executive Vice President

September 24,2001

The Honorable Tommy G. Thompson
Secretary of Health and Human Services
200 Independence Avenue, SW
*6*15F Hubert H. Humphrey Building
Washington, DC 20201

Dear Secretary Thompson,

On behalf of our nearly 5,000 member hospitals, health systems, networks and other providers of care, the American Hospital Association (AHA) is pleased to follow up with you about a regulatory reform issue of critical interest to our members - the Minimum Data Set (MDS) currently used in skilled nursing facilities (SNFs) and in non-critical access hospital swing beds effective July, 2002. Our members operate approximately 2,200 hospital-based or affiliated SNFs and 1,500 members use swing beds.

The implementation of the SNF PPS system has imposed a significant administrative burden on SNFs that must be reduced, particularly in light of the current nursing shortage. Under present requirements, the more-than-400-question MDS can be completed several times in a beneficiary's 15-day Medicare-covered stay typical of hospital-based SNFs. **As** a result, scarce nursing resources are utilized for burdensome documentation rather than patient care. The MDS, originally designed to facilitate care planning and assessment in nursing homes with average lengths of stay of approximately two years, has limited utility for the post-acute SNF population.

On July 26,2001, the Centers for Medicare & Medicaid Services (CMS) announced its decision to streamline the MDS for hospital swing bed services effective July, 2002. The streamlined form is about one-third the length of the full MDS used by SNFs (and nursing facilities) under Medicare and Medicaid program rules. While the effort to streamline the form is laudable and appreciated, CMS's decisions on the swing bed MDS raise three fundamental issues:

- ✓ post-acute oriented SNFs and critical access hospital (swing beds) still have to complete the full MDS despite having a similarly short length of stay for Medicare patients;
- ✓ the draft CMS swing bed MDS does not adequately reflect important characteristics of medically complex patients; and
- ✓ the draft CMS swing bed MDS still contains a number of unreliable and problematic questions.

AHA proposes that the attached form be used by Medicare for all SNFs as soon as possible and for non-critical access hospital swing beds after July, 2002. AHA reiterates its request that the MDS be completely eliminated for critical access hospital swing bed services.

In developing the attachment, AHA started from a base of the current draft swing bed MDS. In general, the deletions to the CMS form were for cognitive and behavioral questions where reliability of the items is below accepted norms and where such questions involve less-frequently used payment categories (i.e., the bottom 18 RUGs). The additions to the CMS draft form emanate from research conducted by Abt Associates as part of a CMS contract to examine

changes to RUGs to better account for non-therapy ancillary utilization in SNFs. We also added a section to more flexibly record diagnoses to assist in identifying medically complex cases while minimizing reporting burden, similar to a question on the existing MDS. The AHA revisions to the CMS draft actually result in a shortened form, while improving its relevance to post-acute care.

More fundamental changes to the form should be addressed when case mix refinements are addressed and again when all post-acute assessment instruments are examined pursuant to the study required by Section **545** of the Medicare and Medicaid Benefits Improvement and Protection Act of 2000. Also, careful consideration should be given to the letter and the spirit of standardization requirements for code sets under the Health Insurance Portability and Accountability Act.

Thank you for your responsiveness to date to our concerns about regulatory burden. We look forward to working with you on this and other issues important to Medicare beneficiaries. If you have any questions, or if we can provide additional information, please contact Brian Ellsworth, senior associate director, policy at (202) 626-2320 or me.

Sincerely,

Rick Pollack
Executive Vice President

Enclosure
Cc: Thomas Scully