ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION

Testimony of the Alaska State Hospital and Nursing Home Association

before the Committee on Health, Education, Labor and Pensions of the U.S. Senate

July 31, 2018

"Reducing Health Care Costs: Decreasing Administrative Spending"

Good morning. My name is Becky Hultberg, and I am the President/CEO of the Alaska State Hospital and Nursing Home Association. On behalf of my member hospitals, health systems and skilled nursing facilities, thank you for the opportunity to testify today and for addressing this critical topic. Health care providers face a variety of administrative burdens, from state, local and federal regulations, to billing and insurance-related administrative costs. I will focus my remarks on the growing number of federal regulations and the impact of this administrative burden on our health care system.

Health care providers and regulators share the same goals of improving quality and keeping patients safe. Hospitals, health systems, and post-acute care providers recognize the importance of a stable regulatory framework. Such a framework would allow them to focus on patients, rather than paperwork, and to invest resources into improving health care access, cost, and quality. We appreciate recent work done by the Centers for Medicare and Medicaid Services (CMS) in addressing regulatory burden, such as the "Meaningful Measures" initiative, and changes to the Promoting Interoperability Program, but given the volume and complexity of new and existing federal regulation and the pace of regulatory change, more work remains to be done.

Close to 24,000 pages of hospital and post-acute care federal regulations were published in 2016 alone. The American Hospital Association (AHA) quantified the direct cost of compliance for America's hospitals in a 2017 report entitled, "Regulatory Overload: Assessing the Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers." Hospitals, health systems, and post-acute care providers must comply with 629 discrete regulatory requirements across nine domains, spending $39 billion annually in administrative activities related to regulatory compliance. For an average-sized community hospital (around 160 beds), this equates to spending more than $7.5 million annually on

regulatory compliance, with 59 staff dedicated to this purpose. Larger hospitals spend as much as $19 million on compliance activities. The average community hospital spends over $750,000 annually just on the information technology investments required for compliance. To put these numbers into the context of patient care, the regulatory burden costs $1,200 every time a patient is admitted to a hospital.

The Requirements of Participation (RoPs) issued for skilled nursing facilities (SNFs) in October 2016 provide an example of the overwhelming burden of regulatory change. The implementation cost of the new rule is estimated at $831 million, with annual costs of compliance exceeding $735 million, or nearly $100,000 per building. This is at a time when all-in margins for skilled nursing facilities are only 0.7%, according to the Medicare Payment Advisory Commission.

Most often, we discuss administrative burden in terms of direct costs, however it is equally important to recognize opportunity costs. The opportunity cost is the next best thing you could do with the financial and human resources spent on something, or the value of the foregone alternative. It highlights the reality of scarcity, that when a dollar or staff hour is spent on administrative activities, it is not available for something else. Financial and human resources spent in regulatory compliance activities cannot be used for adding new services, implementing new patient safety initiatives, caring directly for patients, hiring physicians and nurses, or addressing needs within our communities.

Rapid improvements in quality and patient safety are occurring at scale in our nation's hospitals and skilled nursing facilities. Voluntary partnerships between CMS and providers to improve quality, like the Partnership for Patients and the American Health Care Association's Quality Initiative, are resulting in significant, measurable improvements in patient care. Alaska hospitals participate in the Washington State Hospital Association Hospital Improvement Innovation Network (HIIN), one of 16 such networks around the country. HIINs are sustaining and accelerating change, delivering real results for patients. As an example, working together, Alaska hospitals reduced the rate of death from severe sepsis and septic shock from 20 percent, to just under five percent in two years. Behind

those statistics are real people, someone's mother, someone's friend, someone's child, alive today because of this work.

As part of the Quality Initiative, skilled nursing facilities are improving on nearly every metric. Nursing hours have been steadily increasing over the past five years. SNFs have shown national improvement in 20 of the 24 quality outcomes measured by CMS, and the rehospitalization rates for all admissions, regardless of payor status, have been steadily decreasing. The proportion of patients admitted for post-acute care who are discharged back to the community has steadily increased over the past five years. This equates to 142,000 fewer hospitalizations, and $1 billion in savings to the health care system. SNFs in Alaska are doing better than the national average on overall Five Star rating, RN staffing rating, off-label antipsychotic use, and long-stay falls with injury.

These partnerships are examples of the power of collaboration in improving patient safety. We must focus our resources on the quality improvement partnerships yielding meaningful outcomes for patients.

All hospitals, health systems, and post-acute care providers feel the weight of burdensome administrative processes and regulations. As we consider both the direct and opportunity costs of administrative burden, it is helpful to consider the impact on our most vulnerable health care providers.

The issue of administrative burden comes into sharp focus in rural America. The volume of regulation and complexity of the regulatory framework requires scale to implement - and rural areas lack scale. Spreading these costs over a small population is increasingly difficult for our smallest providers. The nation's rural hospitals and skilled nursing facilities simply cannot continue to effectively comply with an ever-growing mountain of federal regulations. For a large hospital, the opportunity cost of a regulation may mean a program delayed, but for a small town, the choice may be much more difficult. The opportunity cost of regulatory burden for rural hospitals and skilled nursing facilities may be the loss of these services for the residents of that community.

The federal government can take steps to address the growing volume of federal regulations, while ensuring patient safety. There should be better alignment and application of regulatory requirements within and across federal agencies and programs; as well as clear, concise guidelines and reasonable timelines for the implementation of new rules. Some examples for consideration include Medicare Conditions of Participation (CoP) for hospitals; the Promoting Interoperability Program; Stark Law and civil monetary penalties; and reforms in Post-acute Care (PAC).

Medicare Conditions of Participation. CoPs for Medicare are a significant source of the cost of regulatory compliance and should be evidence-based, aligned with other laws and industry standards, and flexible. Medicare CoPs require providers to adhere to established health quality, safety, and operational standards to participate in the Medicare programs. There is tremendous value in the CoPs to ensure the safe delivery of care; however, the administrative components to certify that hospitals adhere to all standards present a growing burden to providers.

According to the AHA's 2017 report on regulatory overload, hospitals spend, on average, $3.1 million annually for administrative compliance activities on hospital CoPs. Hospitals strive to be fully compliant with all the requirements all of the time, but that effort is made more difficult and onerous if the requirements lack clarity or conflict with the requirements of other standards-setting organizations. Accreditation bodies should streamline and modify standards so that they support integrated and coordinated care, and ensure that regulations are clear, well-vetted, and consistently enforced.

Promoting Interoperability Program. Hospitals and health systems appreciate recently proposed changes to the Promoting Interoperability Program, formerly the EHR Incentive Program, that focus on relieving regulatory burden and the importance of interoperability. While hospitals support various proposals that introduce flexibility in the program's requirements, there are several areas of concern. In the FY2019 Inpatient Proposed rule, CMS asks for input regarding the opportunity to further advance interoperability of health information through the creation of CoPs for hospitals and critical access hospitals and

conditions for coverage (CfCs) for other providers. Hospitals strongly oppose creating additional CoPs/CfCs to promote the interoperability of health information. A new mandate tied to CoPs is not the right mechanism to advance health information exchange. CMS should recognize impediments to information sharing and address them directly. Creating a CoP or CfC that would apply to only one set of actors is not an appropriate strategy. Further, it is not clear that such requirements would have any greater impact on interoperability than the existing ones; however, they could have unfortunate consequences for some hospitals and communities.

We do not recommend that CMS implement a CoP/CfC to increase interoperability across the continuum of care, because post-acute care providers were not given the resources or incentives to adopt health IT. Adding this requirement would place yet another unfunded mandate on these providers and would be workable only if all facilities were afforded the same opportunity to acquire certified EHRs that conformed to standards enabling the kind of interoperability CMS envisions.

Hospitals would benefit from additional time to implement and optimize the 2015 edition certified EHR technology. Experience to date indicates that the transition to a new edition of certified EHR technology is challenging due to lack of vendor readiness, the necessity to update other systems to support the new data requirements, and the time required to review and modify workflows and build performance. We are concerned that the 2019 transition will present additional challenges due to new reporting requirements, and the requirements to use EHR functionality that were not included in the 2015 edition certification criteria. At this time, hospitals lack widespread experience with the 2015 edition certified EHR. CMS should examine current experiences to inform proposed future program requirements.

Hospitals oppose the use of Stage 3 requirements in FY 2019. The level of difficulty associated with meeting all of the Stage 3 current measures is overly burdensome. Some of the measure thresholds require the use of certified EHRs in a manner that is not supported by mature standards, technology functionality, or an available infrastructure. The costs associated are significant for hospitals and health systems without demonstrable benefit,

especially for smaller facilities with negative margins. Small hospitals are often forced to buy expensive upgrades totaling tens, if not hundreds of thousands of dollars, with reporting functionality they don't need. For a hospital barely staying afloat, that is a significant expenditure.

Stark and Anti-Kickback. Congress, CMS and the Office of the Inspector General should revisit Stark Law and other requirements aimed at combatting fraud to provide the flexibility necessary to support coordinated, high-quality, high-value care.

Hospitals and health systems are adapting to the changing health care landscape and new value-based models of care by eliminating silos and replacing them with a continuum of care to improve the quality of care delivered, community health, and overall affordability. However, portions of the Anti-kickback Statute, the Ethics in Patient Referral Act (also known as the "Stark Law") and certain CMPs stand in the way. Congress should create a safe harbor under the Anti-kickback Statute to protect clinical integration arrangements so that physicians and hospitals can collaborate to improve care and eliminate compensation from the Stark Law to return its focus to governing ownership arrangements.

Post-Acute Care. The PAC field continues to undergo a major transformation. In FY 2018, all long-term care hospitals will have transitioned to the new, two-tiered payment system, under which one out of two cases is paid a far lower "site-neutral" rate that is comparable to an inpatient prospective payment system (PPS) rate. Also underway are CMS's regulatory efforts to reform the skilled nursing facility and home health PPSs, with refined proposals for payment models expected for 2019.

Given the scope of the changes already underway for post-acute care, we urge Congress to reject new changes or payment cuts that would reduce payment accuracy or increase administrative burden for these services, as such changes could threaten access to medically necessary care. Instead, we encourage the facilitation of changes that will preserve access to medically necessary care, improve payment accuracy, and streamline excessive regulatory demands.

Skilled nursing facilities face huge new unfunded mandates to hire staff and establish compliance programs in the 2016 RoPs, that, due to their sheer volume and specificity, are difficult if not impossible to implement. The rule includes updated standards of practice, consideration for different types of residents in nursing centers, and other changes that CMS believes will improve care for residents. We support changes that focus on patient-centered care and improving outcomes. However, many provisions require SNFs to develop new infrastructure and extensive documentation, along with adding new staff positions that create redundancy and add cost without demonstrable benefits to residents. Regulatory changes on issues ranging from pharmacy services to transitions of care mean well, but create a large unfunded mandate. Noncompliance with any of these changes puts a SNF's Medicare and Medicaid qualification on track for termination.

CMS implemented an 18-month moratorium for imposing the most severe remedies for noncompliance with eight out of 249 distinct regulatory citations, but providers still must implement these changes. Nurses and other clinical staff are being pulled from the bedside to develop and update more than 20 different written policies and procedures, and to complete other administrative tasks prescribed in the RoPs. For example, the new regulations require providers to copy and fax a detailed transfer notice to the Long-term Care Ombudsman every time a resident is transferred to the hospital for emergency care or a planned hospital-based procedure. Requiring this level of documentation beyond what is required in a resident's medical record or other resident communication takes staff away from patient care without improving outcomes or saving costs. CMS should revise the SNF RoPs to make them more outcome-focused and patient-centered.

Federal law regarding the RoPs unduly burdens small states. The federal survey requirement is carried out through state governments, with federal oversight surveys ensuring compliance. Federal law requires that CMS survey five percent of SNFs within a state, or a minimum of five facilities. With 18 facilities, our members have a far higher survey burden than the 1,202 facilities in California. This means they spend more time on paperwork, and less on patient care. We urge Congress to address this inequity by changing

statute to create a single, consistent standard for all states. Thank you to Senator Murkowski for her interest in this issue.

Finally, we ask Congress to address the unintended consequences of the revocation of Certified Nursing Assistant (CNA) training programs when a SNF receives a CMP above a certain level. The recent increase in the use of CMPs as an enforcement tool is another well-intentioned idea with harmful unintended consequences. CNAs, who provide much of the care for SNF residents, are trained in programs run by SNFs. These training programs are revoked for two years when CMPs of a certain amount are issued, regardless of whether the CMPs were related to caregiving. The increase in the use of CMPs retrospectively and for citations unrelated to resident harm has resulted in many CNA training programs being revoked unnecessarily. These programs help to address the nationwide shortage of health care workers, while offering free job training to often economically disadvantaged individuals who would otherwise have to pay hundreds or thousands of dollars for similar career-track education. We recommend that the automatic revocation of CNA training be addressed through changes to federal statute.

Conclusion. The federal regulatory framework is intended to protect patients, ensuring that they receive safe, high-quality care, a goal shared by providers. However, not all regulations achieve this objective, and well-intentioned guidance can cause harmful unintended consequences. Where regulations add cost, without any benefit to patients, they should be reviewed and modernized or eliminated. Where they are duplicative, they should be streamlined. A commitment to patient safety means a commitment to investing our time and resources into activities that demonstrably improve patient safety, not those that simply check a box or fill out a form. We look forward to continuing to partner with federal regulatory agencies in this work. Thank you for your commitment to improving the nation's health care system.