Issue
Academic medical centers (AMCs), which include clinical faculty providing care to patients at teaching hospitals, are leaders in delivering coordinated care for clinically complex and vulnerable patients while also performing innovative research and training the next generation of clinicians. Within this unique environment, AMCs must comply with federal regulations and policies. While a certain level of federal oversight is necessary, the government needs to reexamine and modify regulations that are limiting delivery system reform and innovation.

Background
In recent years, health care delivery models have changed significantly. In January 2015, the Administration announced goals and an aggressive timeline for shifting Medicare reimbursements from quantity to quality and value. AMCs are increasingly moving to new ways to deliver care. As they, and all health care providers, respond to the new federal policies, the Centers for Medicare and Medicaid Services (CMS) must update its regulations and regulatory processes to reflect the new delivery system environment. Many regulations were developed years ago in the context of a fee-based reimbursement. AMCs are increasingly moving to new ways to deliver care. As they, and all health care providers, respond to the new federal policies, the Centers for Medicare and Medicaid Services (CMS) must update its regulations and regulatory processes to reflect the new delivery system environment. Many regulations were developed years ago in the context of a fee-based reimbursement. A January 18, 2011, executive order (E.O. 13563) emphasizes the importance of reducing regulatory burden and costs. Specific regulatory actions that should occur to reduce unnecessary burden, improve care, and promote delivery reform are discussed below.

Improve self-referral and anti-kickback regulations to accommodate delivery reform
To achieve the goals of delivery system reform, there is a need for changes to federal laws and regulations affecting hospital-physician arrangements, including the Physician Self-Referral Law (also known as “Stark”), the Anti-Kickback Law, and the Civil Monetary Penalties (CMP) Law. Since enactment of the self-referral law, there have been major changes in health care delivery and payment, including many initiatives to align payment with quality and to improve coordination of care. Provisions in these laws, which were enacted to address issues in a fee-for-service system, present significant barriers to clinical and financial integration aimed at improving the quality of care, population health, and reducing costs. The Office of Inspector General (OIG) of the Department of Health and Human Services should create a new safe harbor, and CMS should create a new Stark self-referral exception to enable financial arrangements that involve risk sharing and gain sharing in alternative payment models when appropriate safeguards are in place. These arrangements pose little risk of program or patient abuse and are intended to provide better quality care at reduced cost. Conditions set forth by the OIG and CMS for obtaining a waiver from the anti-kickback and self-referral laws for providers participating in the Bundled Payment for Care Improvement (BPCI) Model, the Shared Savings Accountable Care Organization (ACO) program, and the Comprehensive Care for Joint Replacement (CJR) Model could be used as criteria for a waiver.

ISSUE SUMMARY
While regulation is necessary for safety and patient protection, hospitals, physicians, and other providers spend too much time and too many resources on unnecessary regulatory paperwork and compliance that divert from patient care. Many regulations were developed decades ago when reimbursement and delivery models were different. As the health care delivery system evolves, the AAMC supports initiatives to reduce, simplify, modernize, and harmonize regulations and recommends that any newly needed regulations be applied prospectively and have clear objectives.
Remove skilled nursing facility three-day hospital stay rule, pay for telehealth services in more locations, and waive direct supervision requirement for home visits

To better coordinate and improve care for patients, CMS should allow waivers of the three-day skilled nursing facility (SNF) rule, which requires that a patient spend three days as a hospital inpatient before being eligible for SNF services. This requirement is an impediment for providers trying to reduce costs and improve quality. For some patients, the most appropriate care is at an SNF after a short hospitalization or an observation stay. Yet, currently, selecting the most appropriate care means that the SNF stay would not be covered by Medicare.

The general Medicare rules related to payment for telehealth services require that the services be provided to a patient in a rural area and at an originating site defined by CMS. The home is not included as an originating site. Patients in urban and other areas who do not have convenient access to a provider could also benefit from telehealth. Certain alternative payment models (APMs), such as Next Generation ACOs, have telehealth waivers available, but such waivers should also be provided to other APMs.

CMS should waive the direct supervision requirement for postdischarge home visits so that nurses could provide services, without a physician present, in the homes of beneficiaries who are not homebound.

As Medicare payments move toward having a strong quality component, there is little risk that these changes would result in services being used for other than the best quality, most cost-efficient care. CMS should eliminate policies that impede good care and could result in financial penalties for both providers and patients.

Align quality measures across payers

The number of quality measures that providers must report to CMS and other payers is increasing rapidly in the inpatient and outpatient quality programs. CMS should align the measures used by both the Medicare and Medicaid programs as well as commercial payers to reduce burden and prevent confusion. A key step would be development of a national core measure set, with measures that apply across health settings and across payers. CMS should focus on measures that are critical to driving the best possible outcomes for patients.

Prevent inconsistent and duplicative audits

Medicare subjects providers to claims review by multiple entities including Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), Zone Program Integrity Contractors (ZPICs), and Comprehensive Error Rate Testing Contractors (CERT). These redundant and overlapping audits place an enormous burden on providers and have resulted in inappropriate denials. There is a need to streamline and eliminate these duplicative audits.

AAMC Policy Recommendations

- The AAMC supports initiatives to reduce, simplify, modernize, and harmonize regulations.
- The AAMC recommends that any new regulations be limited in scope and, if necessary, be applied prospectively and have clear objectives.
- Specific regulatory areas that a new administration should review and address include fraud and abuse regulations that restrict new delivery models, inconsistent and duplicative audits, alignment of quality measures, waivers of the SNF three-day stay, expansion of payment for telehealth services, and home visits requirements.

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