

## **HHS Issues Final Plan to Ease Burdensome Regulations**

### **Atlanta Hospital News**

**By Jennifer Tyler**

#### **October Issue**

As directed by President Obama in Executive Order 13563, the Department of Health and Human Services (“HHS”) has issued its final plan (the “Plan”) for reviewing and modifying burdensome regulations. Many of the regulations targeted by HHS directly affect hospitals and ancillary health care providers.

President Obama’s Executive Order 13563 directs each executive agency to establish a plan for ongoing retrospective review of existing significant regulations to identify those rules that can be eliminated as obsolete, unnecessary, burdensome, or counterproductive, or that can be modified to be more effective, efficient, flexible and streamlined.

HHS’s Plan, issued August 22, 2011, sets forth in detail HHS’s system for reviewing, modifying and evaluating the effectiveness of its regulations. According to the Plan, HHS will prioritize the regulations that its agencies can easily modify, streamline or rescind to address regulatory burdens and inefficiencies. Next, HHS directs its agencies to identify regulations that may be ripe for review because of changes in circumstance. The retrospective review will not occur in a single exercise, but will entail a periodic review of existing significant regulations.

The Plan contains a preliminary list of regulations the agencies within HHS have identified as candidates for review over the next two years. Some of the major initiatives affecting hospitals include:

- Use of Telemedicine to Increase Access – The Centers for Medicare and Medicaid Services (“CMS”) published a final rule on May 5, 2011, eliminating the requirements that providers be credentialed at every facility in which they are providing service via telemedicine. CMS estimates that roughly \$13.6 million in net savings will result from this initiative.
- Aligning the Electronic Health Record (“EHR”) Incentive Program with other Electronic Reporting Systems – CMS intends to eliminate outdated or redundant quality measures and standardize reporting methods. As part of this goal, CMS issued, on September 6, 2011, a final rule modifying the e-prescribing program to align better with the EHR Incentive Program. CMS hopes the change will reduce confusion in the physician community and reduce the reporting and paperwork burdens.
- Revisions to the HIPAA Privacy Rule – The Office for Civil Rights is undertaking a number of revisions to the HIPAA Privacy Rule, including changes to facilitate disclosure of student immunization records to schools and easing burdens on health plans associated with distributing notices of privacy practices.

CMS is also considering changes to remove barriers to individuals trying to access their own health information held by laboratories.

- Conditions of Participation for Hospitals – CMS has conducted a large scale retrospective review of the conditions of participation it imposes on hospitals to remove or revise obsolete and unnecessary or burdensome provisions. CMS intends to publish a proposed rule this fall and estimates that the revisions may save as much as \$600 million annually.
- Aligning Medicare and Medicaid – CMS is initiating review of conflicting requirements between Medicaid and Medicare that create potential barriers to high quality, seamless and cost-effective care for dual eligible beneficiaries.
- Removing Actuarial Determinations for Pension Costs – CMS finalized in the Inpatient Prospective Payment System rule for 2012 to eliminate the requirement that Hospitals rely on actuarial determination to report their pension costs. This revision relieves hospitals of an unnecessary and burdensome reporting requirement and is expected to save hospitals \$375,000 per year.

Overall, CMS, the agency responsible for the administration of Medicare and Medicaid, has approximately 80 reform proposals under review and development. CMS has also received a multitude of specific suggestions for regulatory review from the public. For example, commenters suggested streamlining claims review by multiple contractors including Medicare Parts A and B Recovery Audit Contractors (“RACs”), Medicare Administrative Contractors (“MACs”), Medicaid Integrity Contractors (“MICs”), Comprehensive Error Rate Testing Contractors (“CERTs”) and Zone Program Integrity Contractors (“ZPICs”), which are often described as redundant; and (2) adding flexibility in physician self-referral regulations. These are just a few of suggestions received by CMS.

Although the comment period has already ended for HHS’s Plan, hospitals interested in suggested regulations for review need not be concerned. The Plan confirms that an integral part of the regulatory review process is increased breadth and quality of public participation. HHS has even established a Public Participation Task Force to explore ways to increase interactivity in the public comment process, including the use of podcasts, webinars, video teleconference, Wikis, YouTube and other social media.