MEDICARE RED TAPE RELIEF PROJECT
MGMA RESPONSE: COMMITTEE LETTER
APPENDIX I

August 25, 2017

The Honorable Kevin Brady, Chairman
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal, Ranking Member
Committee on Ways and Means
1139E Longworth House Office Building
Washington, DC 20515

The Honorable Patrick Tiberi, Chairman
Subcommittee on Health
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

The Honorable Sander Levin, Ranking Member
Subcommittee on Health
Committee on Ways and Means
1139E Longworth House Office Building
Washington, DC 20515

Dear Chairman Brady, Ranking Member Neal, Chairman Tiberi and Ranking Member Levin,

On behalf of the Medical Group Management Association (MGMA), I commend you for initiating the "Medicare Red Tape Relief Project" to reduce legislative and regulatory burdens on Medicare providers that impede innovation, drive up costs, and stand in the way of delivering better care for Medicare beneficiaries. MGMA stands ready to work with you and your colleagues on the Committee on Ways and Means, Subcommittee on Health in creating a new era of innovative, high quality, and efficient care delivery untethered from excessive, one-size-fits-all regulations.

MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, advocacy and education, MGMA empowers medical group practices to create meaningful change in healthcare. With a membership of more than 40,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 organizations of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

In addition to recommendations for reducing legislative and regulatory burdens on medical group practices outlined below, we are attaching the results of the MGMA 2017 Regulatory Burden Survey, which includes responses from more than 750 group practices with the largest representation in independent medical practices and in groups with 6 to 20 physicians. The results indicate no shortage of opportunity for the Medicare Red Tape Relief Project, as medical practices are currently flooded with red tape and bureaucracy, requiring redirection of limited resources from clinical quality improvement and patient care toward compliance with federal rules and regulations. In fact, more than 80% of respondents agree or strongly agree that a reduction in Medicare's regulatory complexity would allow their practice to reallocate resources toward patient care.

As you launch this laudable project to modernize the regulation of America's care providers and medical group practices, MGMA appreciates your consideration of the following priority areas for regulatory relief.

Simplify the Merit-Based Incentive Payment System (MIPS)

Repealing the problematic sustainable growth rate and retiring a hodgepodge of quality reporting programs, the Medicare Access and CHIP Reauthorization Act (MACRA) charted a value-based trajectory for the Medicare payment system by valuing innovative, patient-centric and efficient care delivery over check-the-box bureaucracy. However, as implemented, MIPS is an overly complex program that focuses on the quantity of reporting rather than the quality of care provided to patients. MIPS continues to take a siloed approach to reporting, as it consists of four distinct components under one broad umbrella. This approach is extremely burdensome and incompatible with Congress's goal of reducing the cost of healthcare. At this critical juncture in Medicare's transition from fee-for-service toward value-based reimbursement, Congress has a chance to make tweaks to the program that would align it more closely with the original intent of MACRA.

We offer the following legislative refinements to the MACRA statute, which have the potential to reduce the complexity and burden in MIPS:

- ***Maintain 90-day reporting period for all MIPS categories***
    - **Ask:** Instruct the Secretary of Health and Human Services (HHS) to reduce all MIPS data collection requirements to the minimum statistically-valid sample, such as a 90-day reporting floor.
    - **Rationale**: Without sufficient rationale, the Centers for Medicare and Medicaid Services (CMS) proposed to increase the data collection period for the quality category of MIPS from a minimum of 90 consecutive days to one calendar year, significantly increasing the reporting burden on clinicians and groups. As MIPS requires participants electing to submit quality data via registry, qualified clinical data registry, or electronic health record on all patients, including those with commercial insurance coverage, any 90-consecutive day window should provide a reliable data set. Claims-based reporting, which is limited to Medicare beneficiaries, may require a longer data collection window, such as six months. Medical group practices are struggling to comply with the 90-day data collection and reporting requirement. Needlessly increasing the reporting requirement does not help translate a higher quality of care, but rather a greater quantity of data reporting. A shorter quality measure reporting period would not only reduce the burden but also allow CMS to shrink the problematic two-year lag between performance in MIPS and the payment adjustment year, increase the timeliness of feedback, and set benchmarks on more current data.

- ***Establish quarterly feedback***
    - **Ask:** Instruct the Secretary to provide feedback about MIPS performance at least every calendar quarter.
    - **Rationale**: Although MACRA instructs CMS to provide quarterly feedback to MIPS participants, CMS has yet to implement this critical feature of MIPS. Instead, the agency provides feedback once per year, six months after the close of the performance period. Without timely feedback, MIPS is essentially a reporting

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exercise that enters data into a "black box" only understood by CMS, rather than a useful barometer practices can leverage to drive quality improvement. MGMA's long-standing position is that CMS should provide ongoing, real-time measurement and performance feedback to all impacted physicians and group practices. Equipped with this data, practices would be able to understand their past performance, identify potential areas for improvement, and make necessary adjustments to successfully participate in MIPS.

- ***Delay prematurely measuring cost***
    - **Ask:** Extend the Secretary's authority to weigh the cost performance category below 30% beyond the first two years of MIPS. CMS should delay measurement of clinicians and groups on cost until it is operationally feasible to provide regular resource use and attribution feedback on at least a quarterly basis.
    - **Rationale**: At this time, many features of the cost performance category are unfinished. Notably, episode-based measures are still being developed, while new patient attribution mechanisms will be tested in 2018. It is crucial for CMS to understand the complexities of patient attribution and take this opportunity to fully test any new code set to ensure the agency achieves the desired outcome of appropriately assigning costs to providers who have control over the care. There are also several significant barriers to successful implementation of the patient relationship codes, including the need for a nation-wide provider outreach and education effort and the requirement that practice management system software be upgraded and deployed to all physician practices. Moreover, CMS needs additional time to finetune methodological aspects of cost, such as risk and specialty adjustment. Thus, an appropriate ramp-up period is necessary to ensure a smooth roll out of the cost component of MIPS.

- ***Pause new Certified EHR Technology (CEHRT) mandates***
    - **Ask:** Permit MIPS and APM participants to continue using EHR products meeting the latest certification standards and encourage the Secretary to develop a more user-centric certification as outlined in the 21st Century Cures legislation.
    - **Rationale**: Although the 2018 Quality Payment Program (QPP) proposed rule would allow ongoing use of current CEHRT, CMS is expected to mandate all QPP participants move to a newer CEHRT product in 2019. Less than 100 products are currently certified to the new standard, raising concerns about the feasibility of moving every medical group practice in the country to a new technology platform without the prerequisite vendor readiness. Additionally, as discussed later in this letter, the current Office of the National Coordinator for Health Information Technology (ONC) certification is undergoing an overhaul, as Congress recognized in the 21st Century Cures Act that the certification program must incorporate user-centered design and focus more on facilitating interoperability. It is therefore appropriate to pause the anticipated government mandate requiring group practices move to a new ONC-certified product until HHS has established a more sustainable, user-friendly certification approach.

- ***Increase flexibility to appropriately score MIPS performance***

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- **Ask:** Add language increasing flexibility in the MIPS scoring methodology so reporting one data point counts across MIPS categories. Congress should also make language recognizing performance improvement more flexible.
- **Rationale**: One of the principal goals of MACRA was to consolidate three disparate and complex federal quality reporting programs into one. Yet MIPS continues to take a siloed approach to reporting, as it consists of four distinct components under one broad umbrella. We believe CMS should recognize high-value behavior with cross-category MIPS credit. For instance, reporting quality measures via EHR should count toward fully meeting the advancing care information (ACI) category, rather than merely toward bonus points. Additionally, there are significant obstacles to measuring performance improvement at this time. Group practices operate in a fluid environment of recruitment, acquisition, expansion and reduction. Even if the group composition remains identical between performance years, CMS would not advise how the group can improve for up to 18 months– a gap that does not allow adequate time to implement actionable changes to drive improvements. Further, the agency has just one year of data to judge improvement.

Expand Advanced Alternative Payment Model (APM) opportunities

- ***Reduce the nominal amount standard (aka nominal risk standard)***
  - **Ask:** Instruct the Secretary to reduce the nominal amount standard, particularly the revenue-based standard which is currently set at 8% of revenues, and consider other types of financial risk toward this calculation.
  - **Rationale**: CMS has never provided methodology behind the 8% nominal amount standard and we feel this definition far exceeds the "more than nominal" requirement set forth in MACRA and sets an unnecessarily high barrier to Advanced APM participation. In 2017, only six models qualify as Advanced APMs, and two are not currently accepting new applicants next year. Lowering this minimum standard is the most effective way to generate increased Advanced APM opportunities. Practices that would not have been able to participate in an Advanced APM could join new, lower risk models, while more sophisticated practices could continue to join higher risk models which also feature higher levels of reward. Additionally, costs inherent to starting an APM including startup costs, staff training and investment in new technologies can easily exceed millions of dollars by CMS' own estimates, and should be counted towards an APM's nominal amount standard. Incorporating these risks could lead to many more APM Entities entering this track of MACRA and additional APMs, such as the Medicare Shared Savings Program Track 1 participants, finally being recognized for the very tangible risk they are assuming.

- ***Calculate the nominal amount standard at the APM Entity level***
  - **Ask:** Instruct the Secretary to calculate the nominal amount standard at the APM Entity level, as opposed to the APM level.
  - **Rationale**: For APMs that do not expressly define total risk in terms of revenue, CMS proposes to average the Medicare Parts A and B revenue at risk for all APM Entities within the APM and determine whether that amount meets the 8% nominal amount standard. This approach could disadvantage smaller APM Entities as setting

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a universal standard based on average collective revenues would be much higher for smaller APM Entities proportionate to their separate revenues and could be financially untenable. This adverse selection could also lead to the average growing even higher, causing a slippery slope that would drive larger and larger APM Entities from being able to participate.

- ***Remove Advanced APM restrictions***
    - **Ask:** Instruct the Secretary to remove unnecessary restrictions that prevent APMs from qualifying as Advanced APMs. Specifically- remove the clinician limit and primary care focus requirement on Medical Home Models (MHMs).
    - **Rationale**: In MACRA, Congress supported the expansion of medical homes as a cornerstone of value-based payment reform. To date, CMS has not created any medical home alternatives outside of MHMs that would qualify as Advanced APMs and restricts MHMs to those with a primary care focus and fewer than 50 clinicians. These restrictions unnecessarily prevent specialty-focused and larger models that have been successful in driving down costs from qualifying as Advanced APMs and instead force them into MIPS.

- ***Count Medicare Advantage (MA) towards the Participation Threshold Medicare Option***
    - **Ask:** Clarify the Secretary has statutory authority to count MA payment arrangements toward the Medicare Option for the Advanced APM Participation Threshold beginning with the 2019 performance period.
    - **Rationale**: Nowhere in MACRA did Congress specifically limit the beneficiary count standard to Medicare fee for service patients. Today, one out of every three Medicare beneficiaries is enrolled in an MA plan. APM Entities serving these patients as part of their Medicare population and should be able to count these beneficiaries toward their Advanced APM participation under the Medicare Option through the beneficiary count alternative.

- ***Expand Physician-Focused Payment Models (PFPMs)***
    - **Ask:** Instruct the Secretary to count Children's Health Insurance Program (CHIP), Medicaid, and Medicare Advantage (MA) APMs toward the definition of PFPMs.
    - **Rationale*:*** Expanding the definition of a PFPM to include models with these payers would allow greater opportunities for practices to participate in Advanced APMs, particularly specialties that treat patients outside the traditional Medicare population.

- ***Broaden scope of the PFPM Technical Advisory Committee (PTAC)***
    - **Ask:** Instruct the Secretary to assist PFPM developers, and establish a formal process for testing and implementing PFPMs recommended by PTAC, requiring a response to all PTAC recommendations within 60 days.
    - **Rationale**: By establishing PTAC, Congress took an important step toward facilitating the development of new physician-led, innovative models to help broaden the path to participation in Advanced APMs. However, as pointed out in the 2018 QPP proposed rule, HHS is under no statutory obligation to test these models. To

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date, two proposals were recommended by PTAC for limited-scale testing and more than 60 days has passed without a response from HHS. Additionally, CMS retains the unique ability to collect clinical and payment data across payers and, up to this point, has offered a limited support in providing PFPM developers with this vital data. Without statutory assurances that PFPM developers will receive the data they need to develop these models, or that models recommended by PTAC will ever be tested or implemented by HHS, PTAC has little credibility and could eventually cease to serve a practical purpose as developers grow tired of continuing to invest resources with nothing concrete to show for it.

Enact administrative simplification

By some accounts, administrative costs in the U.S. healthcare system total in excess of $300 billion annually, or nearly 15 percent of all healthcare expenditures in the nation.[1] Further, these administrative costs add to clinician frustration and serve, as in the case of health plan prior authorization mandates and other requirements, as a clear impediment to patient care. When the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996, one of its goals was decreasing the burdensome and costly administrative overhead experienced when providers and health plans interact. While the law required the development of a wide range of national standards for critical electronic transactions including verifying patient insurance eligibility, claim submission, prior authorization, attachments, and remittance advice, for various reasons the industry has still not reaped the full benefit of these standards. More than twenty years after the passage of HIPAA, several critical standards have yet to be promulgated by the government, while others have not been updated or are simply not enforced. This has led to a continuation of manual administrative processes that, if corrected, could save the healthcare industry billions of dollars.

MGMA urges Congress to consider the following legislative opportunities to simplify the administration of health care in the United States:

- ***Standardize electronic attachments***
    - **Ask:** Instruct the Secretary to expedite released of an electronic attachments regulation.
    - **Rationale**: Transmitting clinical data using administrative transactions is commonplace in today's healthcare environment. Often this data is required to support claim submission and prior authorization requests. Yet even when the claim or prior authorization transaction itself is sent electronically, the supporting clinical documentation must be sent manually, often via fax or mail. The result is costly and inefficient movement of data that can delay payment for medical services and even delay the care patients need. The adoption of these standards for electronic attachments would greatly improve and streamline administrative transactions and improve clinical data exchange. Transitions of care, care coordination and care management, as well as clinical quality reporting would be enhanced with a standard for electronic attachments. Significant stakeholder savings would result from reduction in phone calls, mailings,

[1] Wikler E, Basch P, Cutler D,"Paper Cuts—Reducing Health Care Administrative Costs," Center for American Progress (2012); Health Costs: Health Spending Explorer, *Kaiser Family Foundation* (2015); Casalino, L. P., Nicholson, S., Gans, D. N., Hammons, T., Morra, D., Karrison, T., & Levinson, W., "What does it cost physician practices to interact with health insurance plans?" *Health Affairs*, 28(4) (2009).

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claim denials and claim appeals. Further, by simplifying and standardizing the movement of clinical data, electronic attachments would serve to support the nation's move to APMs.

Simplify the electronic health record (EHR) certification

The incentives associated with the Medicare and Medicaid Meaningful Use EHR Incentive Program were helpful in facilitating the adoption of EHR technology in physician practices, but excessive regulatory strings have caused extreme frustration for physicians caring for patients. ONC implemented an EHR certification process that required software vendors to divert research and development resources away from implementing physician-friendly design to meeting seemingly arbitrary government requirements. This regulatory environment has resulted in lost productivity and additional cost associated with the current certified EHR technology. Further, despite widespread use of EHR technology, and the outlay or more than $30 billion dollars in federal incentives, the industry has also not yet achieved the level of interoperability that would result in significant clinical and administrative improvements promised at the outset of the federal incentive programs.

We offer the following recommendations to provide greater flexibility in the certification standards to match the health information technology needs of physician practices:

- ***Simplify health information technology (HIT) certification***
    - **Ask:** Develop a public-private initiative to improve HIT certification process in line with 21st Century Cures Act and include practice administrators on federal HIT advisory bodies. HHS should also take the opportunity to improve the alignment of technology with clinical practice and better support the delivery of high-quality care.
    - **Rationale**: The current EHR certification does not meet the needs of physician practices, as it is overly focused on meeting reporting requirements. In fact, in the MGMA 2017 Regulatory Burden survey, 87% of respondents reported they have at least a moderate level of concern with federally-mandated EHR certification requirements. To further laudable and achievable industry interoperability goals, ONC needs to significantly overhaul its certification program. Most importantly, ONC should modify its certification program to validate that EHR software not only meets established interoperable standards and quality reporting program requirements, but more importantly, contains the functionality necessary to support the real-world needs of clinicians.

Roll back restrictions on furnishing telehealth services in Medicare

Ask: Roll back a myriad of restrictions preventing widespread adoption of telehealth services by approving the CONNECT for Health Act or similar legislation.

Rationale: Telehealth technologies have the potential to be a cost-effective and quality-focused method for delivering medical services to millions of Medicare beneficiaries, yet they are greatly inhibited by Medicare's coverage requirements, including originating site restrictions, geographic limitations, and limitations on covered codes. Congress has an opportunity to waive these restrictions for certain providers who are preparing for the new MIPS or participating in a qualifying APM, permitting remote patient monitoring for certain patients with chronic conditions, and adding telehealth as a basic Medicare Advantage service. The bipartisan, bicameral CONNECT

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for Health Act (H.R. 2556/S. 1016) would advance telemedicine's goals of improving patient access and quality, and reducing costs.

Telehealth services will play a growing role in coordinating care for patients with complex needs and allowing timely exchange of important health information as practices continue to focus on bettering their clinical practice improvement activities and prepare to assume financial risk under the framework of APMs established in MACRA. By reducing barriers to telehealth coverage, Congress would allow physician practices to leverage innovative technology to increase access for Medicare beneficiaries. The challenge that practices will face with APMs is finding innovative ways to deliver care at a lower cost. Telehealth is a prime way to do this.

Repeal the Independent Payment Advisory Board (IPAB)

Ask: Repeal the IPAB by approving H.R. 849 or similar legislation.

Rationale: The IPAB is a 15-member board of non-elected officials who would develop proposals to maintain Medicare spending below a targeted per capita growth rate. The board's proposals receive special expedited consideration by Congress. The legislation that created the IPAB includes several barriers that inhibit Congress from rejecting proposed cuts to Medicare payments. MGMA is deeply concerned with empowering an independent commission to mandate payment cuts for physicians, who are already subject to an expenditure target and other payment reductions under the current Medicare physician payment system. Further, payment cuts under IPAB have the potential to significantly disrupt and interfere with Medicare's move toward value-based payment in the QPP.

Delay changes to the Clinical Laboratory Fee Schedule (CLFS)

The Protecting Access to Medicare Act (PAMA) of 2014 was enacted by Congress to revise Medicare reimbursement methodology for services furnished under the CLFS, based on data submitted by applicable laboratories that report commercial payer pricing data. As implemented, the PAMA regulation is widely anticipated to result in cuts to clinical laboratory testing reimbursement, which jeopardizes the availability of clinical testing and patient access to these services in the setting where patients receive most of their medical care.

Ask: Delay implementation of the new CLFS pricing scheme, except in the case of sole source clinical tests, since data submissions are reasonably expected to be accurate given the limited test menus and the final amount can be reasonably validated by the sole source laboratory, and for any additional tests where factors establish a high data integrity and transparency of private payer payment calculation. Additionally, the Administration should modify existing regulations to conduct market segment surveys of all laboratories, including reference labs, POLs, independent labs, and hospital community labs, to validate and adjust the final amount calculated based on the data collection to ensure that congressional intent achieved that CLFS rates accurately reflect private market payments.

Rationale: New payment rates under the CLFS will be effective Jan. 1, 2018, meaning Congress still has the opportunity to implement adjustments to the framework and avoid projected negative consequences to the physician office laboratory (POL) community. Among a number of pressing concerns, the most immediate is that the integrity of the data for calculating payment rates is not

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accurate given that the data collection period was retrospective, pricing data is incomplete and excludes all hospital labs and virtually all POLs, and the methodology to aggregate each clinical test payment is not clear or transparent. The lack of data integrity does not reasonably reflect congressional intent to establish a correct weighted median for each test on the Medicare CLFS and moreover, will result in patients experiencing reduced access across the board to clinical laboratory testing and to in-office testing. Laboratories have reported they did not have adequate time to collect and verify the required pricing information and that, in some cases, partial payments have been reported as total payment, particularly in the case of paper claims.

At a time when relief from overly burdensome regulation has become a top priority, we urge Congress to ensure that implementation of PAMA results in as little burden and disruption as possible.

Allow reimbursement for required services under Section 1557 of the Affordable Care Act (ACA)

Ask: Allow for Medicare reimbursement to practices administering language assistance services to individuals with limited English proficiency (LEP). To the extent that any add-on code is created, it should not include a cost-sharing obligation for LEP patients when receiving preventative services for which coinsurance is waived.

Rationale: Regulations promulgated under Section 1557 of the ACA include a requirement to take reasonable steps to provide meaningful access to LEP individuals. There is no dedicated funding available to group practices to implement nondiscrimination requirements, and while some states provide reimbursement for written translation and oral interpretation services, there is no such framework at the federal level.

Laudable efforts to prevent discrimination in health programs and activities have had the unintended consequence of costly administrative burdens, particularly for small medical group practices in underserved areas. The cost to provide language assistance services is not inconsequential, and medical group practices are reporting financial losses when treating patients that require interpretative services. This is further exacerbated when LEP patients postpone or do not appear for an appointment, since the practice must still reimburse the interpreter. Providing reimbursement at the federal level would help offset the costs incurred to provide these services free of charge and appropriately reimburse medical group practices for the increased physician and clinical staff time required to care for LEP patients. We recommend waiving any cost-sharing obligation for LEP patients, as requiring a coinsurance payment could result in inadvertent consequences such as creating a separate class of patients based on nationality, which stands in stark contrast to the very intent of the law.

Repeal the Stark Physician Self-Referral Law

Ask: Repeal the outdated physician self-referral law in its entirety, or at least the compensation "prong" of the prohibition on self-referral, which needlessly interferes with the types of incentive based compensation relationships that can drive quality and reduce cost in Medicare's post fee-for-service environment.

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Rationale: No serious effort to reduce regulatory burden in the Medicare program would be complete without consideration of the Federal Physician Self-Referral Law. This statute has become, over twenty-five years and through innumerable CMS rule-makings, a regulatory monster of mind-numbing complexity. Even large health systems with in-house counsel and compliance resources far beyond those available to most physician group practices in MGMA's membership have difficulty understanding every nuance of the regulations, leaving them in a position of regulatory uncertainty and risk. The original Stark law was developed to deal with potential over-utilization of health services in a predominantly fee-for-service environment. Medicare's payment environment today is radically different, and with successful implementation of MACRA, will resemble even less the world for which the Stark law was designed. The Stark law was also intended to be a "bright line" alternative to the intent-based Anti-Kickback statute, but it has never provided the desired clarity and certainty. Repeal of all, or substantial parts, of the Stark law would still leave truly abusive referral relationships subject to the anti-kickback law which, in combination with the False Claims Act, has proven to be a much more effective enforcement tool than it was perceived to be 25 years ago. Even the law's original Sponsor, Congressman Fortney "Pete" Stark of California, observed in recent years that had he known it would turn into a regulatory nightmare and classic "lawyers and accountants relief act," he would never have proposed it in the first place.

The Ways and Means Committee, working with the Senate Finance Committee, took exactly the course MGMA is advocating now, more than 20 years ago, when Congress voted to eliminate the compensation prong of the law. Unfortunately, that forward-looking step was part of a large budget bill vetoed by President Bill Clinton in his 1995 standoff with the Republican-controlled Congress. We submit that it is time, once again, to revisit the Stark law in its entirety: Did it ever accomplish its original goals? Has it outlived its usefulness? Does it impede care coordination between hospitals and physicians? Is it beyond "fixing," given the repeated regulatory efforts at improvement, every one of which simply added to the complexity of the regulatory scheme?

MGMA would like the opportunity to meet with you and your staffs to explore these issues and devise a legislative solution that would significantly relieve the enormous regulatory burden which the Stark law represents.

Conclusion

Thank you again for the opportunity to provide comments regarding opportunities to lower costs, improve quality and encourage more innovation in Medicare. As you move forward, please do not hesitate to use MGMA as a resource. We share the Subcommittee's interest in providing relief from regulations and mandates that impede innovation, drive up costs and prevent the delivery of better care for Medicare beneficiaries. Should you have any questions, please contact me at agilberg@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

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