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2019 Issue Brief Regulatory Improvements for Value-based Models

Issue

Medicare regulations have increased in number and in scope and are a significant contributor to provider burnout. Importantly, many federal regulations actually impede the physician-patient relationship. AMGA supports the efforts of Congress and the Administration to reduce Medicare's regulatory burden. We also support Congress' goal of transitioning Medicare into a value-based purchaser of care.

The best way to address the issue of regulatory burden, while simultaneously incentivizing Medicare's transition away from fee-for-service, is to link the regulatory reform efforts described below to providers participating in value-based payment models. Linking these two critical policy goals would incentivize providers to take steps toward value-based arrangements and would reward those that already have taken this step. Those providers that voluntarily choose not to follow this value-based path can still practice as they always have in the current environment.

AMGA contends that the following regulations can be refined to improve AMGA members' ability to deliver care improvements in value-based models of care.

AMGA asks that Policymakers address the following issues:

Quality Measurement: Payers should reduce the number of quality measures for all value-based providers and move to a more outcomes based system supported by claims data. AMGA developed a value-based set of measures that are evidence based and improve care as well as the patient experience. **Policymakers should work to harmonize and scale down the amount of existing quality measures for all providers in value-based arrangements.**

Meaningful Use Stage 3: AMGA remains unconvinced that the substantial investment in time required to complete Stage 3 Meaningful Use (MU) documentation actually improves patient care and patient outcomes. **Since the benefits of requiring Stage 3 MU is both uncertain and since Stage 3 product selection limited, we believe that policymakers should suspend this health information technology requirement.**

Preferred Provider List: Under current Medicare regulations, patients discharged from an acute care facility and are in need of post-acute care (PAC) follow-up treatment are simply provided information on PAC facilities in their area. Under the Next Generation Accountable Care Organization (ACO) demonstration, providers are allowed to present patients with a list of preferred PACs that meet certain quality criteria, including a minimum star rating. This policy

helps ensure Medicare beneficiaries receive care in a higher-quality care setting. Providing a beneficiary with a preferred provider list simply offers them more information and improved care transparency. **The Medicare program needs to be reformed, so that all providers are afforded this ability to inform patients of high-quality PAC providers.**

Physician Self-referral Stark Law Reform: Federal legislation and regulations governing physician self-referral, collectively termed the “Stark Law,” were intended to prevent financial conflicts of interest around physician self-referrals in fee-for-service (FFS) settings. As Medicare transitions to value-based arrangements, the need for these protections and related self-referral and anti-kickback regulations lessen, as incentives to over-utilize healthcare services diminish. Participants in the Medicare Shared Savings Program or ACO program often have to receive several fraud and abuse waivers since the financial incentives push providers to improve the continuity, coordination, and continuum of care for assigned ACO beneficiaries. The Stark Law’s prohibitions, which were drafted 30 years ago, impede the physician-hospital relationships necessary to address overuse of services. The Stark Law was drafted to address volume of service increases in FFS Medicare. It has virtually no application in value models, which incentivize appropriate use of services. **Therefore, this law should be updated to account for changes in care models that have led to more integrated care delivery.**

Telehealth: Telehealth and remote-monitoring services offer Medicare beneficiaries substantial access and care improvement opportunities, including self-management support, comparatively better outcomes, and higher patient satisfaction. Telehealth also leads to greater spending efficiency for the Medicare program. **To increase patient access to telehealth services, policymakers should follow through on the expansion of telehealth payment in the Medicare Advantage patient population and waive the geographic limitations for telehealth use for all providers participating in value-based models.**

3-Day Qualifying Inpatient Stay for Skilled Nursing Facility Care: The Social Security Act requires Medicare beneficiaries to have an inpatient hospital stay of no fewer than three consecutive days to be eligible for Medicare coverage of skilled nursing facility (SNF) care. This rule dates back to the inception of the Medicare program, and is referred to simply as the SNF 3-Day Rule. The three-day stay is not required for other forms of post-acute care, including home health care or inpatient rehabilitation facility stays. Today, under pay-for-value arrangements, the 3-Day Rule has become, as the Medicare Payment Advisory Commission (MedPAC) previously noted, “antiquated.” **Policymakers should waive the qualifying inpatient stay requirement and implement policies that encourage providers to work with their patients to provide services in the most clinically appropriate location.**