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August 25, 2017

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

Re: Medicare Red Tape Relief Project

Dear Chairman Tiberi:

Thank you for your continued interest in federal healthcare programs at the House Ways and Means Subcommittee on Health. As you know, the Medicare program provides health care to approximately 55 million American seniors and as the “market maker” influences how care is delivered to millions more throughout the healthcare sector. We applaud your “Medicare Red Tape Relief Project,” intended to reform government policies in an effort to improve the patient-physician relationship, foster improvements in care quality and clinical practice innovation, and reduce spending growth. On behalf of our members, we offer the below recommendations in the hopes they will assist you in this effort.

AMGA is a trade association leading the transformation of health care in America. In addition to representing more than 450 multispecialty medical groups and integrated systems of care, we advocate, educate, and empower our members to deliver the next level of high performance health care. AMGA is the national voice promoting awareness of our members’ recognized excellence in the delivery of coordinated, high quality, high-value care. We represent more than 175,000 practicing physicians who are part of our member organizations, and in total, deliver care to one in three Americans.

AMGA supports policies that generally reduce the Medicare programs’ regulatory reach so our member providers are best able to expend their energies and talents toward providing the best possible patient care, rather than divert their attention toward regulatory compliance activities that do not improve the patient experience. Our overarching legislative and regulatory goals revolve around advancing the shift of fee-for-service (FFS) payment to reimbursement based increasingly on value or outcomes. AMGA believes regulations should be limited in order that providers are free to innovate. As you are well aware, value-based models such as Accountable Care Organizations (ACOs) and other Alternative Payment Models (APMs) are designed to incent

timely and appropriate care in the most clinically appropriate setting, while driving down spending or spending growth.

AMGA believes the best way to address issues of regulatory rulemaking, while simultaneously incenting Medicare's transition away from FFS, is to link the regulatory reform efforts described below to providers participating in value-based payment models. Linking these two critical policy goals would incent providers to take steps toward value-based arrangements and also 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 believes the following regulations can and do compromise AMGA members' ability to deliver care improvements in value-based models of care. We welcome the Subcommittee's review of these proposed changes.

### **Quality Measure Reporting**

As has been well documented by MedPAC and others, the Medicare program uses far too many process measures that have little to do with improving healthcare outcomes—such as reduced hospital admission rates, bed days or emergency department use, or reductions in spending growth. Current quality measurement benchmarking and performance measurement also are, research shows, financially burdensome. Additionally, Medicare's quality measure sets do not align between and among Medicare programs, for example between ACOs and Medicare Advantage, nor do they align with commercial payers, adding to Medicare provider burden.

The Centers for Medicare & Medicaid Services (CMS) should reduce the number of quality measures, place increasing emphasis on outcomes and patient experience of care measures, and move to increasingly to passive or claims data reporting. These actions would improve care quality, reduce provider administrative burden, and, we hope, reduce spending growth.

### **Nursing Home Reform**

#### ***3-Day Qualifying Inpatient Stay for SNF 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. Referred to simply as the SNF 3-Day Rule, the rule is not required for other forms of post-acute care, including home health care or inpatient rehabilitation facility (IRF) stays. Medicaid does not have a comparable rule. CMS has waived the 3-day rule in the Medicare Advantage (MA) program and has exercised its waiver authority to lift the requirement in select pay-for-value models, including Track 3 of the Medicare Shared Savings program and the Next Generation ACO demonstration.

Today, under pay-for-value arrangements, the 3-Day Rule has become, as MedPAC has noted, "antiquated." The rule actually hinders timely and appropriate care, impedes care coordination, heightens the risk of iatrogenic harm from extended hospital stays, and is a burden on beneficiaries and their family caregivers. AMGA believes CMS should waive this requirement for

all providers participating in Medicare value-based arrangements. We recognize there is concern that waiving the rule will lead to overutilization. However, we believe the evidence for this is at best unclear. This point aside, we believe that under value-based arrangements, providers have no incentive to overprescribe SNF use.

### ***Preferred Provider List***

Under current Medicare regulations, patients who are 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. The common example is a Medicare beneficiary in need of PAC follow-up after a lower extremity joint replacement or a hip or knee arthroplasty. Under the Next Generation 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. It does not obligate them to choose a specific PAC provider. The policy should be extended beyond the Next Generation ACO demonstration to all providers participating in Medicare value-based arrangements. “Discharge planning” from an acute-care setting has long led to confusion and a lack of coordination for Medicare beneficiaries. This proposal begins to redress the longstanding problem, helps reduce hospital readmissions, incents PACs to improve their quality of care, lowers the risk of potential iatrogenic harm, and helps reduce spending growth.

### **Appropriate Use Criteria**

Under the Protecting Access to Medicare Act of 2014, CMS will require providers to consult specified appropriate use criteria (AUC) before ordering advanced diagnostic imaging services as a condition of payment. This raises concerns that AUC and their use within a clinical decision support mechanism will be burdensome for providers and may elevate a tool that is intended to guide physicians to one that prescribes what clinical action is required. Fortunately, CMS is proposing to delay the effective date of the requirement until January 2019. This delay, however, does not ameliorate the flaws in the underlying requirement. The AUC framework was designed to address overutilization of high-end imaging services for Medicare patients. However, this overutilization issue is largely moot in value-based models, as providers are incented to decrease utilization and cost while improving quality. Therefore, AUC regulations should not be imposed on providers in value-based payment models.

### **Chronic Care Management Codes**

In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for Chronic Care Management (CCM) services furnished to Medicare patients with multiple chronic conditions.

The code requires structured recording of demographics, problems, medications, and medication allergies using certified electronic health record (EHR) technology. The code requires a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31 of the calendar year preceding each Medicare PFS payment year. A full list of problems,

medications, and medication allergies in the EHR must inform the care plan, care coordination, and ongoing clinical care.

Though well intentioned, CCM documentation requirements impede use/adoption. CMS should reduce the documentation requirements associated with these codes.

Originally, there was concern that CCM codes would be overutilized. Due to the documentation requirements, however, it appears the opposite effect has occurred; the documentation and reporting requirements have resulted in underutilization of the CCM code. Preliminary data from 2015 suggests that although CMS estimated 35 million Medicare patients could benefit from CCM services, only approximately 100,000 such beneficiaries that year received care management under the CCM codes.

CCM documentation requirements should be reduced. We also recommend that Congress consider eliminating the standard Medicare Part B 20% copayment associated with this benefit. We believe that this copayment presents perhaps the most significant barrier to the use and benefit of CCM.

### **Stage 3 of Meaningful Use**

AMGA continues to have concerns regarding Health Information Technology Stage 3 Meaningful Use (MU). EHR use in payment systems that are based on value essentially make mandatory increased HIT utilization. We remain unconvinced that the substantial investment in time required to complete Stage 3 MU documentation actually improves patient care and patient outcomes. Additionally, HIT vendors have been slow in updating their products to meet Stage 3 requirements. Since the benefits of requiring Stage 3 MU is both uncertain and since Stage 3 product selection limited, we believe the administration should suspend this HIT requirement.

### **Physician Self-Referral Stark Law Reform**

Federal legislation and regulations governing physician self-referral, collectively termed “Stark Law,” were intended to prevent financial conflicts of interest around physician referrals in FFS. As Medicare transitions to value-based arrangements, the need for these protections and related self-referral and anti-kickback regulations are reduced, as incentives to overutilize healthcare services diminish. This explains why participants in the Medicare Shared Savings Program or ACO program receive several fraud and abuse waivers; the financial incentives push providers in these programs to meet their annual financial benchmark and to improve the continuity, coordination, and continuum of care for assigned ACO beneficiaries. Indeed, the Stark law’s prohibitions, which were drafted more than 20 years ago, impede the physician-hospital relationships necessary to address overuse of services.

The nature and goal of the medical group model, as well as new value-based care models, is that providers are incentivized and rewarded for delivering high-quality care that is spending-efficient. However, under current Stark and related statutes, only those structures and arrangements which are expressly permitted may share ancillary services and revenues. This

structure fails to account for the rapidly changing landscape of delivery models that promote increased care collaboration.

### **Advance the Use of Telehealth Services**

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. While Medicare spending on telehealth and remote monitoring services increased an estimated 25% between 2014 and 2015, total spending for the benefit was about \$18 million in 2015, which accounts for less than one-tenth of 1% of total Medicare spending. However, the efficacy of this benefit has been well documented by the Veterans Administration and more than 30 states that require commercial plans to provide such services.

Current Medicare payment regulations generally limit the use of telehealth services and remote monitoring to rural Health Professional Shortage Areas (HPSAs). The Next Generation ACO demonstration grants waivers eliminating both the originating site requirement as well as the geographic prerequisites, allowing assigned Next Generation ACO beneficiaries access to these benefits. AMGA supports waiving the geographic limitations for telehealth use for all providers participating in value-based models.

AMGA appreciates your work to facilitate better care for Medicare patients. We hope that you find these recommendations valuable. We also hope to remain a voice and a resource for the Subcommittee as you continue to develop the “Medicare Red Tape Relief Project.”

Sincerely,

A handwritten signature in black ink, appearing to read "Ryan O'Connor". The signature is fluid and cursive, with the first name "Ryan" and last name "O'Connor" clearly distinguishable.

Ryan O'Connor  
Interim President and Chief Executive Officer  
AMGA