2018 Issue Brief

Regulatory Improvements for Value-Based Models

Issue

Medicare regulations have increased in number and scope and are a major driver in 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.

AMGA believes the best way to address the issue of regulatory burden, while simultaneously incenting 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 incent 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 believes the following regulations can and do compromise AMGA members' ability to deliver care improvements in value-based models of care.

AMGA asks Policymakers to address the following issues:

- **Quality Measurement**: The Centers for Medicare & Medicaid Services (CMS) should reduce the number of quality measures for all value-based providers and move to a more outcome-based system based on claims data.
- **Appropriate Use Criteria (AUC)**: 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. AUC regulations should not be imposed on providers in value-based payment models.
- **Chronic Care Management (CCM) Code**: Though well intentioned, CCM documentation requirements impede use/adoption. CMS should reduce the documentation requirements associated with this code for all value-based providers. In addition, Congress needs to eliminate the beneficiary cost-sharing requirement.
- **Meaningful Use Stage 3**: Meaningful Use Stage 3 regulations should be suspended for all value-based providers as they represent a significant burden on providers without a clear benefit to patients.

- **Preferred Provider Lists**: CMS should allow value-based providers to present patients with a preferred PAC provider list so patients can choose a high value PAC provider.
- **Physician Self-Referral**: The Stark law should be waived for all value-based providers. The Stark law was drafted to address volume of service increases in fee-for-service Medicare. It has virtually no application in value models, which incent reduced volume.
- **Telehealth**: CMS should waive the geographic limitations for telehealth use for all providers participating in value-based models. This would increase patient access to telehealth services.
- **3-day Qualifying Inpatient Stay for Skilled Nursing Facility (SNF) Care**: CMS 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.