



**Statement of the
Medical Group Management Association**

before the

**Committee on Ways and Means
Subcommittee on Health
United States House of Representatives**

Re: Red Tape Relief Initiative Roundtable

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March 15, 2018

On behalf of the Medical Group Management Association (MGMA), I commend the Committee on Ways and Means Subcommittee on Health for convening this roundtable as part of its “Medicare Red Tape Relief Initiative.” MGMA represents 12,500 medical group practices of all sizes, specialties, types and structures, which collectively provide almost half of the healthcare in the United States.

As medical group practices transition to value-based payment to improve the delivery of healthcare, they are hamstrung by burdensome and outdated government mandates that impede innovation, drive up costs, and ultimately redirect resources away from patients. The Centers for Medicare & Medicaid Services (CMS) alone estimates it issues 58 new rules, comprising 11,000 pages, each year. Physician practices need relief from the flood of red tape and bureaucracy.

MGMA requests the Subcommittee utilize its oversight powers and pursue opportunities to relieve regulatory burdens facing medical groups by (i) reducing Medicare quality reporting documentation requirements, (ii) modernizing rules designed for a fee-for-service payment system, and (iii) standardizing critical administrative processes.

Reduce Medicare quality reporting documentation requirements

MGMA appreciates Congress’ ongoing leadership and oversight efforts to ensure successful implementation of the sweeping MACRA payment reforms. We applaud this Subcommittee and all committees of jurisdiction for making technical corrections to MACRA in the Bipartisan

Budget Act of 2018 and signaling continued support of the innovative care delivery improvements taking place in group practices across the country. We are optimistic that these changes will be a catalyst for improving the Merit-based Incentive Payment System (MIPS) beginning in 2019 and expanding advanced Alternative Payment Model (APM) opportunities in the near future.

In 2018, however, group practices are now 74 days into a 365-day quality reporting period without the most basic information regarding whether they are eligible to participate in MIPS. This information gap is exacerbated by the burden of full-year quality reporting with little evidence of improving care compared to a 90-day reporting period. This is unnecessarily burdensome for those reporting providers who will ultimately be deemed excluded from the program and moreover, at odds with Congress' goal of reducing the cost of healthcare, as full-year quality measure tracking and reporting is estimated to cost medical groups close to \$700 million in 2018.¹

Based on a study of MGMA member practices, this cost estimate may be low.² Our research determined that each year physician practices in four common specialties spend, on average, 785 hours per physician and more than \$15.4 billion on quality measure reporting programs. Most of the time spent on quality reporting consists of "entering information into the medical record only for the purpose of reporting for quality measures from external entities."

We urge this Subcommittee to provide immediate relief by working with CMS to shorten the current MIPS quality reporting period to 90 consecutive days. There is precedent for this action. In response to the introduction of legislation to shorten the Meaningful Use EHR reporting period from a full year to three months, CMS retroactively amended its regulations to relieve the onerous reporting burden in 2014, 2015 and 2016. Congress should consider using its influence in the same way to relieve the quality reporting burden for MIPS this year.

Modernize antiquated fee-for-service policies that undercut value-based transformation

In passing MACRA, Congress took a major step toward modernizing our payment system. Unfortunately, remnant fee-for-service (FFS) policies conflict with value-based incentives and undercut the Medicare payment transformation that Congress had originally envisioned.

As practices explore new payment models, they face outdated payment requirements and fraud and abuse rules that hinder their ability to coordinate care. The CMS method to secure waivers is a burdensome model-by-model approval process that takes months. The application deadline for CMS' newest advanced APM passed earlier this week with practices left wondering whether waivers would be approved. Practices accepting financial risk inherently have a strong incentive not to bill unnecessary services and should not be subject to additional hurdles to bill high-value services that keep patients healthy and out of hospitals or to coordinate care among a set of

¹ 82 Fed. Reg. 53577, *Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year*, CMS-5522-FC and IFC.

² Lawrence P. Casalino, David Gans, Rachel Weber, Meagan Cea, Amber Tuchovsky, Tara F. Bishop, Yesenia Miranda, Brittany A. Frankel, Kristina B. Ziebler, Meghan M. Wong and Todd B. Evenson, "US Physician Practices Spend More Than \$15.4 Billion Annually to Report Quality Measures," *Health Affairs* 35, no.3 (2016).

providers that signed an agreement with CMS and passed a fraud and abuse screening.

To address these obsolete requirements, Congress should direct CMS to automatically exempt advanced APMs from redundant Medicare billing and fraud and abuse requirements. Doing so would expedite the advanced APM approval process, save CMS administrative time and costs, and more fully support Congress' goal of driving more participation in these models. As the healthcare industry continues to modernize, Congress should ensure CMS' reimbursement policies keep pace and do not needlessly delay promising treatment and care delivery innovations before they begin.

The time has come for Congress to reevaluate the utility of fraud and abuse laws as we evolve further from the FFS payment environment for which they were intended. The Federal Physician Self-Referral (Stark) Law is a prime example. Over a quarter of a century, the law has evolved into an excessively complex set of regulations that perplexes even the savviest of legal minds. As Medicare continues to shift towards a value-based payment landscape, the Stark law and Anti-Kickback Statute have outlived their usefulness and now interfere with the very types of incentive-based compensation relationships that drive improved quality and reduce cost.

Similarly, the Medicare Appropriate Use Criteria (AUC) program for advanced imaging services established by the Protecting Access to Medicare Act of 2014 needlessly duplicates the reforms and goals of the MACRA legislation. Worse, the program, with its challenging requirements to consult proprietary clinical decision support software and coordinate with other physicians, is likely to disrupt patient care and impose a host of administrative burdens and expenses on medical practices. Most concerning, in a study conducted by the Association for Medical Imaging Management, 60% of respondents estimated it would cost \$75,000 or more to implement a clinical decision support mechanism. Further, MGMA members have expressed concern over the financial security of their practices if their revenue cycle is dependent on the actions of ordering providers at other practices they have no control over. The program's unwieldy logistical design only adds to its burden and CMS itself acknowledges the regulatory complexity and "massive" scope of the program.³ MGMA urges the Subcommittee to support legislative action to pause and revisit the necessity and value of the Medicare AUC program for diagnostic imaging in light of the transition to value-based payment under MACRA.

Standardize critical administrative processes

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.⁴ These costs add to clinician frustration and impede to patient care. The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 with a goal to decrease the burdensome and costly administrative overhead experienced when providers and health plans interact. While the

³ 80 Fed. Reg. 41685, *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016*, CMS-1631-P.

⁴ 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).

law required the development of a wide range of national standards for critical electronic transactions, 22 years later, HHS has still not implemented several of the statutory requirements and the industry has not yet reaped the full benefit of the standards that have been adopted. Further, a number of additional administrative burdens could very easily be reduced or eliminated through federal government action. To increase administrative efficiency, MGMA offers the following recommendations.

The Subcommittee should support the expedited release by HHS of the electronic attachments regulation. Mandated under HIPAA, this electronic transaction has the potential to reduce burden by supporting claim submissions; meeting clinical documentation requirements for prior authorization transactions; and supporting clinician referrals, patient transitions of care, and care coordination documentation requirements. In addition, the electronic attachment transaction can support other clinical and administrative situations where patient data is required to be shared efficiently and securely. Despite being mandated by Congress and its significant potential to streamline communication between providers and plans, HHS has yet to promulgate a final electronic attachments regulation.

HHS should also be instructed to facilitate improvements to the prior authorization process by fully implementing national standards for electronic transactions and operating rules that more effectively automate prior authorization, standardize health plan communications to providers regarding prior authorization requirements, and eliminate prior authorization mandates for medical group practices who have entered into an “at risk” contract with a health plan.

No conversation about increasing administrative simplicity and reducing red tape would be complete without mention of the provider credentialing process. The private sector approach that currently meets the needs of virtually all commercial health plans could easily be expanded to include Medicare and all state Medicaid programs. The burden associated with the Medicare and Medicaid credentialing process would be considerably streamlined with removal of duplicative reporting requirements and the Medicare enrollment and reenrollment process would be significantly simplified for all clinicians. Similarly, HHS could improve the accuracy of provider directory information by streamlining the data collection process for Medicare Advantage plans by collecting this information centrally through a private sector solution and efficiently disseminating the data.

In addition, we urge the Subcommittee to direct HHS to increase the adoption rate for the electronic transactions that lead directly to enhanced system efficiency. At the same time, HHS must curb health plan electronic transaction abuses, such as refusing to support transactions or charging unreasonable fees, through clearer guidance and increased enforcement. In particular, we point the Subcommittee’s attention to the unfair business practices adopted by some health plans and their affiliated payment vendors to charge providers a fee for delivering their payment electronically through the established electronic funds transfer (EFT) transaction. This despite the fact that Congress passed statutory language specially aimed at eliminating paper payments and thereby decreasing the associated printing, mailing, and handling costs for both health plans and providers. It is very disappointing that some industry bad actors have gone against the simplification intent of Congress and fleeced providers by forcing them either accept fees for EFT or fees for processing a “virtual” credit card. The Subcommittee should instruct HHS to

prohibit health plans and their business associates from charging unreasonable fees for HIPAA and EFT transactions.

Finally, the Subcommittee should instruct HHS to establish, as required by statute, a process to certify health plan compliance with all applicable national electronic data interchange standards and operating rules. To date, HHS has not levied any fines on health plans for non-compliance with the HIPAA electronic transactions and operating rules, despite statutory authority to do so and widespread reports of non-compliance and unfair business practices. In the absence of a federal health plan certification process, we urge the Subcommittee to direct HHS to initiate a random audit process on health plans to ensure compliance.

Conclusion

Thank you for the opportunity to share our recommendations for reducing the regulatory burden on physician practices and improving the quality and efficiency of healthcare delivery in this country. MGMA stands ready to work with Congress, HHS, and all other stakeholders in creating a new era of innovative, high quality, and efficient care delivery untethered from excessive, one-size-fits-all regulations.