January 10, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
The Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

The Honorable Christi A. Grimm
Inspector General
Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

Re: Request for Immediate Guidance on Rebilling of Repriced Part B Claims Submitted on or after January 1, 2024

Dear Administrator Brooks-LaSure and Inspector General Grimm:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) thanks you for your longstanding leadership in supporting medical groups' ability to offer high-quality care. Legislative delays affecting Medicare physician fees once again place MGMA members in a position of considerable uncertainty, facing potential billing disruptions and compliance risk. Similar uncertainties face their Medicare patients if services billed currently are later repriced pursuant to congressional action, affecting the application of Part B deductibles and co-payments.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 group medical practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following recommendations.

As it now stands, services provided on or after Jan. 1, 2024, are being billed under the new Medicare Physician Fee Schedule conversion factor with its untenable 3.4% reduction from 2023 levels. Medicare contractors will soon be processing these claims, paying practices, and calculating patient deductible and copay responsibilities, all at the reduced level. Practices will be billing patients for their share of the claim accordingly. Should Congress intervene to retroactively restore the payment cut to 2023 levels, as widely anticipated, these claims will be repriced, payments adjusted, and allowable copays increased.

In that scenario, physician practices will be faced with rebilling patients an additional increment which could in some cases be less than $1.00 and in many, if not most, cases will be small amounts that are less than the administrative cost of rebilling. Such rebilling will leave patients confused, and providers will be blamed even though rebilling is necessary through no fault of their own. Alternatively, providers might choose to forego the incremental copay, but in that event, may risk civil money penalties and even

program exclusion under Medicare's beneficiary inducements statute and regulations (the "Beneficiary Inducements CMP"). Social Security Act 1128A (a)(5) and 42 CFR 1003.1000.

MGMA respectfully requests that in these strictly limited circumstances, assuming they arise, CMS and OIG should immediately advise the physician community that failure to bill *de minimis* (e.g. up to $15 per claim) incremental copays arising from retroactive congressional action will not be considered remuneration, as defined in 42 CFR 1003.101, for purposes of the Beneficiary Inducements CMP. In the alternative, OIG could promulgate a time-limited waiver of the statute applicable to these incremental copays or announce that it would use its discretion not to pursue enforcement action in these circumstances. Any of these three alternatives would be amply justified in the current circumstances for several reasons.

First, any incremental co-pay waived would be attributable to services already rendered to existing patients and would not be advertised or promoted in an attempt to recruit new Medicare patients or provide new services. The motivation for waiving the co-pay would be to reduce patient confusion and save the practice from duplicate billing expenses, not the steering of patients. Thus, the inducement element of the statute would not be implicated.

Second, if the regulatory relief were provided uniformly to all providers, there should be no significant effect on competition, again suggesting that the inducement element is lacking.

Third, the relief would be applicable only to a very narrow slice of billings, specifically those claims submitted on or after Jan. 1 and processed by Medicare's contractors before Congress provides any adjustment to the conversion factor requiring that the claim be reprocessed. If Congress were to act by early February, for example, this would likely be a period of several weeks at the most. Of course, if the Administration and Congress could reach agreement prior to February, this limited window would be further reduced if not eliminated.

Fourth, the relief would be narrowly targeted on incremental copay increases of a *de minimis* nature. MGMA suggest $15 as the appropriate cap per claim so as to be consistent with OIG's existing cap on one-time non-cash gifts to beneficiaries.

Fifth, the relief would have no impact on the ultimate cost-sharing obligations of most beneficiaries since many would have no claims during the limited relief window, and for many others, the annual deductible would not yet have been met, and the full cost of the reprocessed claim, including the increment, would be charged against the deductible.

MGMA appreciates your consideration of this request and looks forward to your response at your earliest convenience. We would be pleased to discuss this with you at any time. If you have any questions, please reach out to me at agilberg@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs