Recommendations relating to MACRA QPP:
#1 - QPP Predictability for Physician Payment
#2 - QPP Implementation Timeline
#3 - Virtual Group Implementation
#4 - Data and Audit Transparency
#5 - MIPS Scoring Methodology

Recommendations relating to Medicare Audit Reforms:
#1 – Reform RAC Payment System
#2 – Extrapolation Standards
#3 – Separate appeals process in RAC program
#4 – Timing of RAC Payments During Appeals
#5 – Establish Right to Appeal RAC decision to use Extrapolation
#6 – Specialty/subspecialty requirement for medical necessity reviews

Other PAI Recommendations for “Red tape” Relief in Medicare Program:
#1 – ACO Issues
#2 – Need for Strengthened Network Adequacy Oversight
#3 – EHR interoperability issues
#3a – EHR/Stage 3 of the Meaningful Use Program
#4 – Medicare Prior Authorization for Covered Services
#5 – Remove Barriers to Physician Owned Hospitals
#6 – Allow Private Contracting
#7 – Revamp Medicare Advantage PSODs for non-covered services
#8 – Lack of EHR Vendor Accountability
#9 – Reduce Burden of Physician Database Checks
#10 – Uncompensated Translation Services
#11 – Mandatory Participation in CMMI Demonstrations
#12 – Annual Wellness Visits
#13 – Telehealth coverage
#14 – Eliminate Identification of Office Staff in Physician Enrollment Forms
Medicare Red Tape Relief Project
Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

Date: August 25, 2017

Name of Submitting Organization: Physicians Advocacy Institute
Address for Submitting Organization: 1010 Mt. Pleasant Road, Winnetka, IL 60093
Name of Submitting Staff: Kelly Kenney, Executive Vice President/CEO
Submitting Staff Phone: (312) 543-7955
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Statutory
Regulatory ✓

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Short Description: Quality Payment Program (QPP) Predictability for Physicians’ Payments

Summary: Participation in the QPP represents a dramatic shift impacting how physicians across the country are paid. Caution should be taken to ensure proposals to change the program do not unintentionally put some patients, physicians, and practices at a disadvantage and/or increase the complexity of the program.

Related Statute/Regulation: CMS 2017/2018 MACRA Payment Year Regulations

Proposed Solution: PAI would like to stress the importance of and need to rely on empirical data from the program to support significant changes that could have a substantial impact on physicians’ reimbursements. Furthermore, there needs to be an assurance that the data supporting any program changes is verified, accurate, and validated. Without transparency and data from the program, it is challenging to affirmatively support changes that could put physicians at risk for greater potential losses.

PAI would like to emphasize the importance of sharing feedback reports on a timely and continuous basis so that practices have adequate time to not only make improvements for the remainder of a current performance period, but also for the subsequent performance period to improve their overall MIPS performance scores. Physicians should be held harmless for lack of timely and actionable feedback reports.
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**Regulatory ✓**

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**Short Description:** Quality Payment Program (QPP) Implementation Timeline

**Summary:** A longer implementation timeline is needed to allow physicians and their staff to learn more about the QPP’s quality measures and prepare for enhanced reporting requirements. As part of the 2017 MIPS and APM Final Rule, the agency finalized several “transition year” policies to help physicians and other eligible clinicians (ECs) transition and become more familiar with MIPS. The policies included “pick your pace” options for the 2017 performance period, which allowed three participation options (not including non-participation), which was granted to physicians for the 2017 payment year to allow them to participate based on their readiness.

**Related Statute/Regulation:** CMS 2017/2018 MACRA Payment Year Regulations

**Proposed Solution:** The “Pick Your Pace” approach should be extended through at least the 2018 performance year. We believe it is important to continue the “pick your pace” policy as many physicians are still trying to understand the MIPS requirements and how their participation in the program will affect their practices. Alternatively, if the “pick your pace” options are not continued for the 2018 performance period, at a minimum, PAI recommends that the agency also offer a 90-day reporting period for the quality category, similar to the ACI and improvement activities categories. This would result in consistency across the performance categories instead of adding another level of complexity to the program, and requiring physicians to keep track of which performance period applies to which category.
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Summary: The CY 2018 Updates to the Quality Payment Program proposed rule aims to provide details about some aspects of virtual groups; however, there are still many aspects that are unclear and could potentially hinder the formation of virtual groups. Without an accessible virtual groups’ option, small and solo physicians are at a disadvantage under the MIPS scoring system.

Related Statute/Regulation: CMS 2017/2018 MACRA Payment Year Regulations

Proposed Solution: CMS should consider awarding bonus points to physicians who form virtual groups to both encourage their formation and account for the fact that smaller practices may receive lower MIPS scores.

Additionally, physicians and groups should have the flexibility to be part of more than one virtual group application and ultimately decide which approved group they would like to align with. We foresee a situation where, if a physician is limited to only one virtual group application, that EC may be left with no options if that application to form a virtual group is denied. This physician would then be required to participate in MIPS on their own, which would likely be difficult for that physician given that they committed to and applied to be part of a virtual group in the first place.

PAI also believes that it is important to extend the application of the Federal Trade Commission (FTC) and Department of Justice (DOJ) Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations (ACOs) Participating in the Medicare Shared Savings Program (MSSP) to virtual groups. This policy statement provides clarity on antitrust issues and guidance on forming procompetitive ACOs. PAI believes that virtual groups will likely incur and have to address similar antitrust issues, and it is important that these be resolved at the beginning rather than mid-
year. The agency should also be mindful of other laws and regulations that could be impediments or obstacles for the formation of virtual groups, and that appropriate exemptions should be extended and applied to virtual groups, for example, Stark Law exemptions that are similar to those for group practices.
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Short Description: Quality Payment Program (QPP) Data & Audit Transparency

Summary: PAI has several concerns with the MIPS data validation, targeted review, and appeal processes. While PAI is actively monitoring the QPP and is aware that the agency has published some materials on the data validation criteria for different performance categories, there remains much uncertainty as to what is required to meet the data validation requirements. Specifically, it remains vague in the current materials available on the QPP website exactly what documentation is required to support an audit. Additionally, physicians who receive a request of an audit currently only have 10 days to respond.

Related Statute/Regulation: CMS 2017/2018 MACRA Payment Year Regulations

Proposed Solution: PAI insists that the agency establish a fair and transparent auditing process, specifying the documentation necessary for audit purposes so there is no misinterpretation by the physician or group, and the agency should ensure that the data validation criteria be posted prior to the beginning of the performance period so physicians and groups have adequate notice of what is expected and required of them. Furthermore, physicians or groups should be granted additional time to respond to an audit request for a valid reason (e.g., patient care, no time/resources, email/letter overlooked, vacation, etc.).

In regard to the targeted review process for appealing a MIPS payment adjustment determination, this is currently a one level, asymmetrical review process. Physicians and groups must currently submit an online application and provide a summary of their position and reason for appealing the payment adjustment determination, to which CMS responds with a final determination via email, and the process is complete. PAI believes it is necessary to expand this process and transform it into a true appeal process. As part of its initial determination and in response to any appeal application, the agency should provide detailed information that clearly explains its rationale for the payment adjustment determination and/or appeal response. Additionally, physicians and groups should have the opportunity to further discuss the
appeal after the agency’s email response to allow them to correct any misunderstanding or gain additional information that could help their performance in the subsequent performance period.
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Short Description: Quality Payment Program (QPP) – Merit-based Incentive Payments System (MIPS) Scoring Methodology

Summary: The MIPS final score and related payment adjustment for physicians and groups is determined based on their performance compared to a MIPS performance threshold. Currently, for the 2017 MIPS performance period, the threshold is set at three points. The agency is considering increasing the threshold to 15 points for 2018. As a result, physicians are unable to anticipate their overall performance scores or payment adjustments because the scores/adjustments are prone to change each payment year and are tied to budget neutrality. This formula creates significant financial uncertainty for physicians across payment years.

Related Statute/Regulation: MACRA Statute (Title 1, Section 101)

Proposed Solution: Amend the MACRA statutory payment adjustment formula to make penalties and bonuses more consistent and predictable across payment years by establishing a predictable threshold schedule with gradual increases at most. PAI believes that an increase from three points to 15 points is too steep at this juncture in program implementation. Instead, PAI recommends a more gradual increase over time, and is supportive of maintaining three points for the 2018 performance period, or, alternatively, increasing the threshold to six points for the 2018 MIPS performance period.
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Short Description: Need to reform the Medicare Recovery Audit Program’s system for compensating Recovery Audit Contractors’ (“RACs”) on a contingency basis.

Summary:
The contingency fee payment system creates a conflict of interest by perversely incenting RAC contractors to inflate their audit findings, resulting in inaccurate audits and erroneous overpayment findings. Many members of Congress have recognized this problem, stating in a February 10, 2014 letter to then HHS Secretary Sebelius: “Due to this payment structure, RACs are incentivized to deny claims, even when the claims are correct.” The Senate Special Committee on Aging has also recognized the problem with the current incentive system. In its staff report Improving Audits: How We Can Strengthen the Medicare Program for Future Generations, the Committee Staff found: “The RAC program pays its contractors based on the amount of improper payments identified through their audits. This creates an incentive to keep improper payments high, rather than to educate providers about how they can better prevent improper payments in the future.” (p. 39) In addition, the Appeal Fairness, Integrity and Reform in Medicare Act (AFIRM), which was reported on a bipartisan basis out of the Senate Finance Committee in 2015, required CMS to study and to provide recommendations to Congress on replacing the incentive payment system without financially burdening providers.

The contingency fee system does not impose any liability on the RACs for errors, which has in turn resulted in the large appeals backlog at the Office of Medicare Hearings and Appeals, significant delays in physician payments, and time and expense wasted by both physicians and government personnel on appeals that would have been unnecessary if the initial audit findings had been accurate. Reforming the RAC compensation system would promote accurate audit determinations and protect the Medicare Trust Fund.

Related Statute/Regulation:
42 U.S.C. 1395ddd(h)(1)
Proposed Solution:

- Strike the statutory provision providing that “(A) RAC payment shall be made to such contractor only from amounts recovered; (B) From such amounts recovered, payment (i) shall be made on a contingent basis for collecting overpayments.”
- Replace the contingency fee system with a retainer-based system or other system that is not based on the payment amount. A new payment system should create incentives for RAC accuracy and disincentives for inaccuracy.
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Short Description:
Recovery Audit Program – Medicare Audit Reform - The need for a statistically valid extrapolation process

Summary: The current approach to extrapolation employed by RACs is inconsistent and often statistically invalid. This often results in drastically overstated overpayment findings that can bankrupt a physician practice. The method of extrapolation is often a major issue in appeals, requiring the appealing physician to hire a statistician to challenge the RAC’s method of extrapolation. CMS should more rigorous, transparent and statistically valid standards and processes for extrapolation. Because this is a complicated topic, PAI offers the following background on extrapolation and the basis for its recommendation.

Extrapolation is a statistical method that uses the results of an audit sample to calculate audit results for the universe of claims from which the sample was drawn. When RAC auditors use extrapolation to estimate the amount of overpayments made to physicians by the Medicare program, excessive amounts can be calculated unless the RACs use a statistically valid and representative sample and an appropriate extrapolation methodology. Although the Medicare Program Integrity Manual (“PIM”) contains general standards for extrapolation (PIM 8.4.2), they lack specificity. In addition, there are other issues with extrapolation that are not adequately addressed in the PIM, including precision and sample size. As a result, audits using extrapolation are often based on inappropriate samples and/or flawed methodologies, resulting in erroneous audit results and excessive overpayment demands.

Physicians appealing RAC audit findings frequently challenge the identification of the sample used in extrapolation and/or extrapolation methodologies and are often successful. Therefore, a more granular set of extrapolation requirements would likely minimize the conflict that results from these types of audits and reduce the burden on the currently backlogged appeals process.

It is particularly important that detailed standards are put in place because the current Recovery Audit Program Statement of Work encourages the RACs “to use extrapolation for some claim types when all
requirements are met.” (Statement of Work for the Part A/B Medicare Fee for Service Recovery Audit Program – Regions 1-4, November 30, 2016, p. 32).

**Related Statute/Regulation:**

Medicare Program Integrity Manual Chapters 1 and 8

**Proposed Solution**

Specific guidelines should be added to the PIM to standardize what tests can be done to ensure that the universe of claims is appropriate for creating a sample. This is important because if the claims universe is highly heterogeneous, it is not appropriate for extrapolation.

The PIM should also be revised to provide more detail regarding the sample frame, which contains the units to be audited for the date range in question. For the most part, the sample frame should present a homogenous picture of the units and lack any issue that could bias the sample. To do this, zero paid claims and outliers should be excluded from the sample frame. In addition, stratification should be used to create more homogeneous subsets. Although the PIM generally discusses stratification, the language should be revised to require that the statistician provide the logic used to create the stratification.

The PIM currently provides that the statistician can use any number of units for the audit, including the beneficiary, a date of service, the claim or the claim line. (PIM 8.4.3.2.2). However, the PIM does not contain any standards to determine which is the most appropriate unit. Unless this is obvious, CMS should require that statistical testing be conducted to ensure that the unit chosen reports low possible variability.

To ensure that the randomization method is correct, the PIM should require that the statistician provide the sample frame or universe to the provider in the same rank order as was used to create the sample, along with the seed value, to allow the provider to replicate the random selection of data.

Nowhere within the PIM is there a discussion of the distribution of the data for the most critical variable, which in most cases is the overpaid amount. The statistical theory on which extrapolation is based requires that the data be normally distributed and that the units be independent. Yet, the PIM does not discuss the importance of normally distributed data, and, as a result, it does not address which metrics to use when calculating the extrapolation. As such, the point estimates, sample error calculations, and precision calculations are often wrong and biased against the physician. In the majority of cases, the distribution will be heavily right-skewed because payments for provider services cannot be less than zero. As such, the distributions are always bounded on the left. The PIM should specify that when the data are non-normally distributed, the auditor must use the median to calculate the point estimate, sample error, and precision. If the data are normally distributed, then the use of the mean could be permitted.

To ensure that the correct extrapolation formula is used for the type of audit, the PIM should be revised to require that the statistician use the ratio for extrapolation in attribute audits, which are audits examining whether claims in the sample should have been paid in full or not at all. The PIM should be revised to require that the statistician use the average for extrapolation in variable audits, which are audits examining claims in which some payment amount should be allowed, although at a lesser amount than originally paid.
CMS recommends that the overpayment estimate be based on the lower bound of a one-sided 90% confidence interval, which is the same as the lower bound of a two-sided 80% confidence interval. This means that there is a 10% chance that the extrapolated estimate is too high. In general, most studies rely upon a two-sided 95% confidence interval and the government should be held to this standard. The PIM should be revised accordingly.

Precision measures the relative distance between data points. Good precision is critical if an extrapolation is to accurately and fairly represent the results reported from a sample, but the PIM does not require any standards for precision. CMS should require RACs to use the same minimum precision standard of 2.5% at a 90% confidence interval as required by the Office of Management and Budget (OMB)\(^1\) for other government agencies.

The PIM standards for sample size in 8.4.4.2 are nebulous and need to be revised to require a minimum sample size of 100, as is required by the OIG in the self-disclosure rules.

\(^{1}\) [Office of Management and Budget] OMB Circular A-123, Appendix C.
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Short Description: The substantial appeals backlog at the Office of Medicare Hearings and Appeals (OMHA) has resulted in significant and unfair delays for providers that challenge erroneous audit findings. Physicians must wait several years to recover payments for appropriately furnished services, creating significant administrative and financial burdens and making it increasingly difficult for physicians to continue to provide services to Medicare beneficiaries.

Summary: Currently, all physician and hospital audit appeals are subject to the same appeals process at the OMHA. Through the 2nd quarter of Fiscal Year 2017, the average processing time for a provider claim is 1,057 days – close to a three-year wait time. CMS has taken certain steps to address the high number of hospital appeals in the backlog, such as a Hospital Settlement initiative that allowed hospitals to receive timely partial payment in exchange for withdrawing the associated appeals. A statutory change is needed, however, to address the burdens that the backlog creates specifically for physicians, who are less equipped than hospitals to handle such a long processing delay and face significant administrative and financial hardships with the current adjudication system.

The need for a separate physician appeals system is even more critical in light of the Recovery Audit Contractors’ (RACs) low accuracy rate at the third level of appeal, which is also the first time that physicians can obtain an independent review of their audits. Data indicates that over half of the RAC claims are overturned at the third level of appeal in favor of physicians, indicating that physicians are currently forced to wait several years to be paid for correctly performed and billed services. In the meantime, the alleged overpayments have usually been recouped from the physicians, often creating cash flow problems, particularly for small physician offices.

In its recent Budget Request, the OMHA stated that “ensuring that providers and suppliers have a forum for independent and timely resolution of their disputes over Medicare payments contributes to the security of the Medicare system by encouraging the provider and supplier community to continue to provide services and supplies to Medicare beneficiaries.” In line with this objective, Congress should enact legislation creating a separate process for physician appeals in order to allow OMHA to speed its review of physician appeals. This would ensure that physicians are not forced to limit or terminate their relationship with Medicare patients due to the risk that they will need to wait years to receive appropriate payments due to an audit. Moreover, a physician-focused appeals track would allow Administrative Law Judges (ALJs) and other adjudicators at OMHA to gain special knowledge and experience with physician billing issues, improving the accuracy of appeal determinations.

Related Statute/Regulation: 42 U.S.C. 1395ff(b)

Proposed Solution: Amend the Social Security Act to create a specialized, separate appeals track for physician appeals to provide more timely and accurate audit reviews. One possible way to approach such a specialized appeals track would be to create a Medicare Magistrate Review program for RAC appeals involving lower dollar amounts.
Such an approach was proposed in the Audit and Appeal Fairness, Integrity and Reforms in Medicare Act (AFIRM), which was reported out of the Senate Finance Committee on a bipartisan basis in 2015.
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Summary:
By statute, RAC auditors are paid on a contingency basis out of the funds collected from providers for alleged overpayments. (42 U.S.C. § 1395ddd(h)(1)). In cases in which a physician has appealed a RAC audit determination, the RAC auditors are currently paid their contingency fees after the physician has “received an unfavorable decision at the first (MAC) and second (QIC) level of the appeal process.” (Statement of Work for the Part A/B Medicare Audit Program Regions 1–4, November 30, 2016, p. 50). There are, however, five levels of appeals from a RAC’s audit findings. Over the last several years, for physicians filing appeals, a significant percentage of the RACs findings have been overturned. For example, CMS’ Recovery Auditing in Medicare for FY 2015 report to Congress showed that 70% of the RAC audit findings appealed by physicians were overturned. (p. 18). Over half of the RAC audit findings for physicians’ claims, however, are overturned in favor of physicians at the third level of appeal, the ALJ level. (See, Department of Health and Human Services Office of Inspector General Report OEI-02-10-3340, pp. 10 and 24). It is unfair to recoup alleged overpayments from physicians and to pay the RAC contractors after the second level of review when the RAC findings are likely to be overturned at the third level of appeal.

Related Statute/Regulation:
42 U.S.C. § 1395ddd(f)(2)(A)
CMS Statement of Work with Recovery Audit Contractors

1 PAI is separately recommending that the contingency fee payment system be eliminating as it perversely incents RACs to find overpayments when there are none.
Proposed Solution:

Section 1893(f)(2)(A) of the Social Security Act (42 U.S.C. § 1395ddd(f)(2)(A) should be amended by striking “until the date of the decision on the reconsideration has been rendered” and inserting in its stead “until the date of the decision on appeal after an Administrative Law Judge hearing.”

CMS should revise its policy such that RACs would not receive a contingency payment until a physician receives an unfavorable ALJ ruling at the third round of the appeal process.
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Short Description:

Recovery Audit Program – Medicare Audit Reform - The need for a statistically valid extrapolation process

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Physicians appealing RAC audit findings frequently challenge the identification of the sample used in extrapolation and/or extrapolation methodologies and are often successful. Therefore, a more granular set of extrapolation requirements would likely minimize the conflict that results from these types of audits and reduce the burden on the currently backlogged appeals process.

It is particularly important that detailed standards are put in place because the current Recovery Audit Program Statement of Work encourages the RACs “to use extrapolation for some claim types when all
requirements are met.” (Statement of Work for the Part A/B Medicare Fee for Service Recovery Audit Program – Regions 1 -4, November 30, 2016, p. 32).

Related Statute/Regulation:

Medicare Program Integrity Manual Chapters 1 and 8

Proposed Solution:

• Specific guidelines should be added to the PIM to standardize what tests can be done to ensure that the universe of claims is appropriate for creating a sample. This is important because if the claims universe is highly heterogeneous, it is not appropriate for extrapolation.

• The PIM should also be revised to provide more detail regarding the sample frame, which contains the units to be audited for the date range in question. For the most part, the sample frame should present a homogenous picture of the units and lack any issue that could bias the sample. To do this, zero paid claims and outliers should be excluded from the sample frame. In addition, stratification should be used to create more homogeneous subsets. Although the PIM generally discusses stratification, the language should be revised to require that the statistician provide the logic used to create the stratification.

• The PIM currently provides that the statistician can use any number of units for the audit, including the beneficiary, a date of service, the claim or the claim line. (PIM 8.4.3.2.2). However, the PIM does not contain any standards to determine which is the most appropriate unit. Unless this is obvious, CMS should require that statistical testing be conducted to ensure that the unit chosen reports low possible variability.

• To ensure that the randomization method is correct, the PIM should require that the statistician provide the sample frame or universe to the provider in the same rank order as was used to create the sample, along with the seed value, to allow the provider to replicate the random selection of data.

• Nowhere within the PIM is there a discussion of the distribution of the data for the most critical variable, which in most cases is the overpaid amount. The statistical theory on which extrapolation is based requires that the data be normally distributed and that the units be independent. Yet, the PIM does not discuss the importance of normally distributed data, and, as a result, it does not address which metrics to use when calculating the extrapolation. As such, the point estimates, sample error calculations, and precision calculations are often wrong and biased against the physician. In the majority of cases, the distribution will be heavily right-skewed because payments for provider services cannot be less than zero. As such, the distributions are always bounded on the left. The PIM should specify that when the data are non-normally distributed, the auditor must use the median to calculate the point estimate, sample error, and precision. If the data are normally distributed, then the use of the mean could be permitted.

• To ensure that the correct extrapolation formula is used for the type of audit, the PIM should be revised to require that the statistician use the ratio for extrapolation in attribute audits, which are audits examining whether claims in the sample should have been paid in full or not at all. The PIM should be revised to require that the statistician use the average for extrapolation in variable
audits, which are audits examining claims in which some payment amount should be allowed, although at a lesser amount than originally paid.

- CMS recommends that the overpayment estimate be based on the lower bound of a one-sided 90% confidence interval, which is the same as the lower bound of a two-sided 80% confidence interval. This means that there is a 10% chance that the extrapolated estimate is too high. In general, most studies rely upon a two-sided 95% confidence interval and the government should be held to this standard. The PIM should be revised accordingly.

- Precision measures the relative distance between data points. Good precision is critical if an extrapolation is to accurately and fairly represent the results reported from a sample, but the PIM does not require any standards for precision. CMS should require RACs to use the same minimum precision standard of 2.5% at a 90% confidence interval as required by the Office of Management and Budget (OMB)\(^1\) for other government agencies.

- The PIM standards for sample size in 8.4.4.2 are nebulous and need to be revised to require a minimum sample size of 100, as is required by the OIG in the self-disclosure rules.

\(^1\) [Office of Management and Budget] OMB Circular A-123, Appendix C.
Medicare Red Tape Relief Project
Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

Date: August 24, 2017

Name of Submitting Organization: Physicians Advocacy Institute
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Short Description:
RAC determinations to overturn treating physicians’ judgment in “medical necessity” reviews should only be made by clinicians with expertise in the specialty or subspecialty at issue.

Summary:
Section 1893(h)(6)(A) of the Social Security Act (42 U.S.C. § 1395(ddd)(h)(6)(A) currently requires only that recovery auditors have “appropriate clinical knowledge of and experience with the payment rules and regulations of this title,” without specifying what those clinical requirements should be for any audits involving review of medical records, such as medical necessity reviews. In the current Statement of Work for the Recovery Audit Program, CMS only requires that “[w]henever performing complex coverage or coding reviews (i.e., reviews involving the medical records), the Recovery Auditor shall ensure that coverage/medical necessity determinations are made by RNs or therapists….” (Statement of Work for the Part A/B Medicare Fee for Service Recovery Audit Program, Regions 1 – 4, November 30, 2016, p. 23).

The Statement of Work requires that the RAC contractors retain a Contractor Medical Director, “who must be either a Doctor of Medicine or a Doctor of Osteopathy who has relevant work and educational experience to oversee the review of Medicare FFS claims.” (Id. at p.10). There is no requirement that the Contractor Medical Director be of any particular medical specialty. The Contractor Medical Director’s duties include “[o]verseeing the medical review process and providing the clinical expertise and judgment to understand LCDs, National Coverage Determinations (NCDs) and other Medicare policy.” (Id. at p. 11).

RACs are “encouraged,” but not required to “utilize the expertise of a panel of clinical specialties, for consultation when performing medical reviews.” (Id. at p. 13).

In order to have the requisite clinical knowledge to conduct audits requiring reviews of the medical record, including medical necessity reviews, auditors must be physicians of the same specialty and
subspecialty as the physician whose records are under review. The absence of a requirement in either the Medicare statute or the RAC contracts requiring that physicians conduct audits requiring reviews of the medical records, much less a requirement that the physician must be of the same specialty or subspecialty as the physician under review can result in inappropriate findings of overpayments, to the detriment of both the treating physician and the Medicare beneficiary whose care is involved.

**Related Statute/Regulation:**
42 U.S.C. 1395ddd(h)(6)

CMS Statement of Work for the Part A/B Recovery Audit Program

**Proposed Solution:**

Amend the RAC statute to require that all medical necessity reviews resulting in a decision to overturn a physician’s medical judgment be conducted by physicians in the same specialty/subspecialty as the physician under review.

Require CMS to include in any future Recovery Audit Program contracts a requirement that all medical necessity reviews resulting in a decision to overturn a physician’s medical judgment be conducted by physicians in the same specialty/subspecialty as the physician under review. If that is not done, at a minimum CMS should be required to revise its Statement of Work to “require” rather than to “encourage” the utilization of a panel of clinical specialists, consisting of physicians of the same specialty/subspecialty as the physician under review in performing medical reviews.
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Short Description: The Centers for Medicare and Medicaid Services’ (CMS) current Accountable Care Organization (ACO) regulations result in serious and significant errors with ACOs’ beneficiary attributions and the shared savings calculations for physicians.

Summary: The beneficiary attribution methodology established by CMS for the ACO program creates significant transparency issues for providers, hinders care coordination, and fails to recognize/reward major care improvements undertaken by providers. The ACO attribution regulations should be revised to give providers a clearer and more predictable way of understanding which beneficiaries will “count” toward their ACO’s yearly performance.

With CMS using a retrospective attribution model for ACO Track 1, providers are unaware which beneficiaries will be factored into their ACO shared savings score until after the performance year has ended. As such, ACOs have devoted considerable time and resources improving the care of older and sicker beneficiaries, only to find out at the end of the performance year that the beneficiaries are not attributable to the ACO. In the cases, the ACOs are not rewarded for efforts such as improved medication adherence and enhanced beneficiary engagement, even when these efforts result in significant savings for the Medicare program. In other instances, particularly when patients temporarily receive care in one state before returning home, ACOs can unexpectedly be penalized for the high costs/poor outcomes of beneficiaries that they did not anticipate accounting for in the ACO. New regulatory measures are therefore needed to give physicians with greater clarity about which patients have been assigned to their ACO, which would allow physicians to engage in more targeted and effective outreach and ensure physicians are rewarded for these efforts.

As a related matter, greater transparency is needed with respect to when CMS will “reopen” its initial determination regarding an ACO’s shared savings amount, such as when CMS erroneously attributed/failed to attribute beneficiaries to the ACO. Although CMS is authorized to reopen its initial determination when evidence indicates that a calculation error was made, CMS has declined to use its reopening authority in several instances, even when an ACO has presented evidence of error. New and clearer regulatory guidance is needed to ensure that physicians can receive a reopening from CMS regarding its shared savings determination when data indicates a beneficiary attribution or other error was made.

Related Statute/Regulation: 42 CFR Part 425

Proposed Solutions:
• Improve the attribution process so that physicians are more aware of which beneficiaries will be attributed to their ACO during the performance year
• Require CMS to clarify its reopening authority and grant physicians with a meaningful avenue for beneficiary attribution review
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Short Description: Medicare Advantage Network Adequacy Standards

Summary: More robust network adequacy standards and oversight are needed in the Medicare Advantage program. Medicare Advantage network adequacy standards do not reflect issues such as provider availability and/or willingness to accept new patients, which is required in Medicaid managed care networks. Current network adequacy standards also fail to reflect key subspecialty services, allowing plans to omit physicians who perform necessary but high-cost services to our nation’s elderly population. This trend to “narrow networks” is well-documented in both Medicare Advantage and in the private insurance market. All too often, beneficiaries are not able to access the full array of covered services.

CMS’ oversight of network adequacy for MA plans is also lacking rigor. Without active oversight and verification of submitted information, even the most comprehensive network adequacy standards will not protect MA beneficiaries from plans that employ various practices to exclude certain health care providers from the networks. For instance, when MA plans terminate physicians or other provider contracts between enrollee enrollment periods, patients often suffer from lack of continuity of care.

Related Statute/Regulation:

Proposed Solution: Network adequacy standards should be refined to account for factors such as providers’ ability to accept new wait times, to better reflect whether the network includes all of the physicians and other health care providers needed to provide timely, comprehensive services to enrollees.

HHS should adopt regulations to ensure more active and meaningful oversight of network adequacy for MA plans.
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Short Description: The regulatory requirements governing Electronic Health Records (EHR) are based on the faulty assumption that EHRs provide the same benefit to all providers and in all settings of care. The EHR regulations should better reflect the different administrative and financial costs that EHR requirements create for physicians, and should create new penalties and standards that apply directly to EHR software vendors.

Summary: The current rules governing physician EHR compliance are prescriptive and create a “one size fits all” approach to EHR use. In practice, EHR systems provide significantly different benefits to providers based on their specialty, practice size, and other variables such as administrative support. While some physicians have found EHR systems that enhance the efficiency of their medical practice, others have found that federally compliant EHR systems do not fit their specialty or office needs. The burden created for many physicians is especially troubling given the administrative and financial costs required for compliance with the federal EHR rules. For example, a 2016 Annals of Internal Medicine study found that some physicians must devote close to 50% of their practice time complying with federal EHR requirements, diverting significant time from patient care.

Because there is no single, interoperable EHR system in place, providers are currently forced to use EHR systems that satisfy arbitrary requirements - such as functional-use measure checkboxes - and yet still face data-sharing and communication issues with other providers. Given the different value that EHRs present for physicians and the fact that interoperability remains a major issue in the health care system, PAI believes that physicians should be allowed to decide whether EHR use and what EHR system is the best fit for their practice.

Furthermore, PAI believes it is appropriate for EHR compliance standards to focus more on software vendors who administer the EHR systems. The EHR regulations should be revised to impose standards and penalties directly on software vendors based on the outcomes of their EHR systems, rather than penalize or reward physicians for their use of such EHR products.

Related Statute/Regulation: CMS EHR Incentive Program Rule

Proposed Solutions:
- Allow physicians to decide whether EHR use is the best fit for their practice
- CMS should issue new regulations that give physicians the flexibility to use specific EHR systems that enhance the efficiency of their practices, rather than systems that satisfy arbitrary technical requirements.
- EHR compliance should be assessed and regulated by imposing requirements on software vendors, rather than making changes to physician payments through the Meaningful Use Program.
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**Short Description:** Electronic Health Records/ Burdens associated with the Meaningful Use Program Stage 3

**Summary:**
Physicians have already faced financial and administrative burdens in complying with the Meaningful Use program, which will become even more onerous when Stage 3 begins in 2018.

Federal requirements, incentives and penalties for electronic health record (EHR) use are based on the assumption that the potential value of EHRs is the same for all specialties and all settings of care. Although many physician practices have acquired EHR systems that do enhance the efficiency or effectiveness of their medical practices, many have found that the available systems do not fit their specialty or their practice setting. Because system design enhancements are now focused on satisfying government requirements rather than user needs, the federal intervention in this marketplace has actually slowed the expected product improvement cycle. EHRs designed to meet government objectives often add features like functional-use-measure checkboxes, which are duplicative processes unrelated to the necessary record of clinical care, decreasing usability and satisfaction.

The net impact of an EHR on quality, cost and efficiency depends on the specific physician, his or her practice setting, specialty and practice variables like available staff support. Rewards and penalties should be based on results, not on the use specific technologies.

**Related Statute/Regulation:**
42 CFR Part 495

**Proposed Solution:** CMS should issue guidance or regulations that cancel Stage 3 of the meaningful use program.
**Medicare Red Tape Relief Project**

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**Short Description:** The lack of clear guidance on prior authorization in the Medicare Advantage (MA) program has allowed MA plans to increasingly utilize these practices. The growing and inconsistent use of prior authorization in MA creates significant administrative and financial challenges for providers and imposes unfair barriers to care for beneficiaries.

**Summary:** Despite the statutory restrictions related to the use of prior authorization practices in the fee-for-service (FFS) Medicare program, CMS regulations do not clearly address if, when and how prior authorization can be applied by MA plans. In light of this uncertainty, MA plans have increasingly used prior authorization practices in recent years and applied these practices to a growing number of services and procedures. This is especially concerning considering that MA plans are statutorily required to cover the same benefits provided in FFS Medicare. Furthermore, MA plans take different approaches to the services subject to prior authorization and the steps required for physicians to obtain prior authorization, creating great uncertainty for physicians and their patients with respect to coverage and payment.

The rising use of prior authorization in the MA program results in significant administrative and financial challenges for physicians. In fact, an American Medical Association (AMA) survey found that 75% of surveyed physicians described prior authorization burdens as “high or extremely high,” and that nearly 90% reported that prior authorization “sometimes, often, or always delays access to care.” Furthermore, PAI members have reported that MA plans have denied coverage even after the physician has received prior authorization, creating additional frustrations for physicians.

Prior authorization practices have also resulted in treatment delays for vulnerable patients. In the same AMA survey, nearly 60 percent of surveyed physicians reported that their practices wait, on average, at least one business day for prior authorization decisions, and more than 25% of physicians report that they wait three business days or longer. With Medicare beneficiaries representing some of the oldest and sickest patients in the nation, these delays can be life-threatening for PAI’s patients.

**Related Statute/Regulation:** 42 CFR 417.414; 42 CFR 422.101; Medicare Managed Care Manual Chapter 13

**Proposed Solution:**
- CMS should issue guidance that clearly establishes when and how prior authorization can be used by MA plans, and establish oversight measures to monitor MA plan compliance with these requirements
• CMS should clarify that, once providers receive prior authorization, MA plans are generally prohibited from subsequently denying coverage
• CMS should create new timeframes for MA determinations on prior authorization requests – such as 24 hours for an expedited request and 48 hours for a standard request – to avoid harmful treatment delays
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Short Description: Physician-Owned Hospital (POH) growth and expansion restrictions

Summary:

The statutory moratoria on physician-owned hospitals have created an artificial, unfair advantage in today’s health care marketplace. As the provider market continues to consolidate, hospitals have taken advantage of these restrictions to acquire physician practices at an unprecedented rate. PAI studied this trend, and found that between 2012-15, there was a near-80% increase in hospital acquisitions of physician practices. The vast majority of these acquisitions were made by non-POHs. As a result, administrators and non-clinicians are increasingly driving medical decisions. Non-POH competitors have benefited from the growth and expansion restrictions facing POHs, despite POHs’ superior performance on many Medicare quality programs.

There is no justification for prohibiting physicians from owning and controlling hospitals while allowing hospital administrators to employ and control physicians. Physicians are professionally and ethically bound to serve the best interest of their patients. Hospital administrators are not. Patient interests are far better served by allowing physicians to exercise control over the facilities in which patient care is delivered. Seven of the top ten hospitals receiving quality bonuses in the Hospital Value-Based Purchasing Program in 2015 were physician-owned, and an analysis by Avalon Health Economics concluded that POHs are saving Medicare $3.2 billion over 10 years. The prohibitions on hospital ownership should be removed immediately.

Related Statute/Regulation: 42 USC 1395nn

Proposed Solution:
Strike the ACA’s restriction on POH growth and expansion and allow POHs to fairly compete with non-POH competitors.
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Short Description: Limits on private contracts between patients and physicians

Summary: Medicare private contracting is the practice whereby the physician and patient agree that the patient will pay for covered services out-of-pocket. CMS interprets current law to prohibit this practice unless the physician completely “opts-out” of Medicare for two years, or unless a service is either not covered by Medicare or deemed by the Medicare carrier not medically necessary. Medicare does not reimburse either the physician or the patient for any portion of the claim when the physician has “opted out” of Medicare. This often forces patients to terminate relationships with their physicians after they opt-out of the Medicare program.

Medicare reimbursement to physicians has not kept up with rising costs of doing business. As a result, more and more physicians are opting out of Medicare altogether or are limiting their Medicare patient panel in favor of higher reimbursing commercial patient panels.

Related Statute/Regulation: 42 U.S.C 1395a

Proposed Solution: Amend the statute to allow beneficiaries to enter into a contract with any physician – regardless of Medicare opt-in or opt-out status – for any item or service covered by Medicare. Beneficiaries could submit claims for Medicare payments at an amount that would be charged if the physician participated in Medicare.
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**Short Description:** Medicare Advantage Prior Authorization Practices for Non-Covered Services

**Summary:**
In recent years, CMS has required physicians to request pre-service organizational determinations (PSOD) from MA plans when patients require non-covered services. This requires patients to make return visits after the PSOD is rendered in writing, even when the patient was willing to receive and pay out-of-pocket for the non-covered service in the initial visit. This requirement creates unnecessary treatment delays and access issues, amounting to prior authorization for services that almost all medical practice administrators know are non-covered. This policy is inefficient and causes delays in treatment. This is particularly problematic for elderly patients who lack accessible transportation to medical appointments.

Prior to CMS’ guidance, MA members were often billed for non-covered services when a provider of non-covered services obtained a detailed waiver or an Advance Beneficiary Notice (ABN) from the member before the non-covered services were provided. This was a more efficient and effective way to ensure the patient had full understanding of his or her financial responsibility before receiving services.

**Related Statute/Regulation:**
42 CFR 422.566-576
CMS Guidance to MA Plans

**Proposed Solution:** CMS should eliminate the use of PSODs and instead allow the use of advance beneficiary notices in the MA program in order to eliminate treatment delays.
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Short Description: Lack of EHR vendor accountability

Summary: Physicians are unfairly penalized when their EHR systems do not comply with federally-set standards.

Related Statute/Regulation:

42 CFR Parts 495
CMS EHR Incentive Program Rule

Proposed Solution:

CMS should issue new regulations imposing standards directly on EHR vendors, rather than levy penalties on physicians through payment adjustments
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Short Description: Administrative Burdens Associated with Medicare Database Checks

Summary:
Sec. 1102 of the Social Security Act (42 U.S.C. 1302) requires physicians who treat Medicare and Medicaid patients to perform monthly checks of online database to determine if any of their employees or contractors have been excluded from a federal health care program such as Medicare or Medicaid. In a May 2013 bulletin, the US Office of Inspector General (OIG) discussed the requirement to screen contractors, subcontractors and employees of contractors in addition to the physician’s own employees. Contractors and subcontractors may also have a large number of employees. For example, a physician may contract with a large national laboratory to test bloodwork. The OIG leaves it up to the provider to determine whether or not to screen for those in addition to his/her own employees. If the provider requires contractors and subcontractors, by contract, to each check their own employees then the provider must validate that the screening is occurring by requesting and maintaining screening documentation from the contractor. The bulletin goes on to state that the provider is still liable no matter who performs the screening and subject to a civil monetary penalty (CMP) if he/she does not ensure that appropriate screening was performed.

Physicians face significant administrative burdens in having to check both the System for Award Management (SAM) and OIG Exclusion database on a monthly basis to ensure all of their hires – which can represent hundreds of individuals - are not in the database/excluded from Medicare. Physicians are forced to take time away from patient care or spend resources on a third party to perform these burdensome, frequent checks.

Related Statute/Regulation: 42 CFR 455.436

Proposed Solution: CMS should issue new rules or guidance to reduce the burden on physician practices to:
• Hold the contractor or subcontractor responsible for the civil penalties associated with failing to appropriately screen for their employees.
• Require that for physician practices, only new hires and/or those employees responsible for submitting claims for payment for direct services to Medicare or Medicaid beneficiaries need to be screened in the database.
• Reduce the administrative burden by mandating that checks should be required every 6-months, rather than monthly.
• In the event that an individual actively misrepresents data, hold that individual accountable for such misrepresentation.
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Short Description: Uncompensated translation services

Summary: In many situations, physician offices are forced to pay for interpreters when treating patients with limited English proficiency, who are deaf or the deaf companions of patients. Patients’ families and friends cannot be used, except in an emergency. The patient cannot be charged for the cost of interpreters and Medicare does not reimburse the physician for the cost of the interpreter. The Internal Revenue Code allows small businesses to receive a tax credit for the cost of complying with the Americans with Disabilities Act. A small business is one whose gross receipts do not exceed $1,000,000 and does not have more than 30 full-time employees. The business may claim a credit of up to 50% of expenditures that exceed $250 but do not exceed $10,250.

The cost for an interpreter can be two or three times the amount the physician will be reimbursed by an insurance plan for the office visit. For example, many sign-language interpreters charge $50 to $145 per hour with a two-hour minimum plus travel reimbursement. Some language interpreters for the deaf make around $125 per hour. Many physicians in rural areas report that medical interpreters are hard to locate or access.

Physicians are forced to bear the costs of providing special translation services without compensation. The lack of Medicare compensation for these services creates incentives for physicians to limit their services for Medicare beneficiaries with translation needs.

Related Statute/Regulation: 42 USC 1395y (new legislation providing payment for translation services needed; 28 C.F.R. § 36.303 (c)

Proposed Solution(s): There are several possible solutions/policies that would ease the burden and cost to physician practices and improve access for patients with limited English proficiency or other disabilities that impede communication with their physicians.

- Medicare coverage laws should be amended to provide payments to physicians who treat patients requiring language assistance or sign interpretation.
• Increase the tax credit to 75% instead of 50% and remove the gross receipts and full-time employees ceiling.

• Create a fund to which physicians may submit claims to receive reimbursement for the services of the interpreter.

• Ease the rules to allow for family member interpreters and other less expensive options.

• Create a fund that provides grants to physicians to install the technology for video remote interpreting services.

• Provide incentive payments to medical practices and clinics to set up centers of excellence that can serve LEP and deaf patients and require health plans to include them in their networks.
Medicare Red Tape Relief Project
Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

Date: August 25, 2017

Name of Submitting Organization: Physicians Advocacy Institute
Address for Submitting Organization: 1010 Mt. Pleasant Road, Winnetka, IL 60093
Name of Submitting Staff: Kelly Kenney, Executive Vice President/CEO
Submitting Staff Phone: (312) 543-7955
Submitting Staff E-mail: k2strategiesllc@gmail.com

Statutory ✓
Regulatory

Please describe the submitting organization’s interaction with the Medicare program: PAI is a not-for-profit advocacy organization focused on securing fair and transparent payment for physicians. PAI’s Board is comprised of CEOs/former CEOs of state medical associations from California, Connecticut, Georgia, Nebraska, New York, North Carolina, South Carolina, Tennessee and Texas and a Kentucky physician. A significant portion of the members of these and other states’ medical societies treat Medicare patients and submit claims to Medicare.

Short Description: Mandatory Center for Medicare and Medicaid Innovation (CMMI) demonstrations do not take into account the specific needs of physicians and their practices, and can result in Medicare beneficiaries losing access to their preferred providers or course of treatment.

Summary: CMMI is charged with testing and evaluating healthcare payment and service delivery models with the goal of increasing quality while reducing program expenditures. In its first years of operation, CMMI implemented voluntary, smaller-scale models that allowed physicians and other providers to participate when their practice, specialty, and patient population was well-equipped to effectively participate (for example, an accountable care organization (ACO) or certain type of bundled payment model). We believe this type of collaborative, provider-led approach is consistent with the statutory intent of CMMI and can help deliver higher quality, lower-cost care to beneficiaries.

Beginning in late 2015, however, CMMI began launching mandatory payment models, where providers are forced to participate in new payment and delivery structures based solely on their geographic location. These models changed the way certain services and drugs are covered and reimbursed, which impacted how and whether physicians subject to these models could treat their Medicare patients. The demonstrations forced many patients lose access to their providers and/or preferred course of treatment, running afoul of CMMI’s goal of reducing costs while maintaining or enhancing the quality of care. Although the CMMI statute is silent as to whether CMMI can launch mandatory models, we do not believe CMMI should be authorized to subject physicians and their Medicare patients – some of the oldest and sickest patients in the nation – to new reimbursement models and care delivery rules without their consent.

PAI applauds this Administration for taking steps to limit the impact of the mandatory CMMI models launched in 2015-2016. We support CMS’ recent proposal to further delay the implementation of the mandatory Comprehensive Care for Joint Replacement Model, as well as its proposed cancellation of the mandatory Episode Payment Models and a Cardiac Incentive Payment model that were scheduled to begin in January 2018. We especially commend CMS’ recent statement that it expects CMMI to “increase opportunities for providers to participate in voluntary initiatives rather than large mandatory episode payment model efforts.” To further ensure that physicians are not subjected to such “large mandatory” demonstrations, we believe the CMMI statute should be amended to clarify that CMMI models can only be administered on a voluntary basis.
**Proposed Solution:** The CMMI statute should be amended to clarify that all demonstrations must be voluntary for physicians.
**Medicare Red Tape Relief Project**  
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**Short Description:** Medicare Annual Wellness Visits (“AWV”)  

**Summary:** As part of the Affordable Care Act, if a Medicare beneficiary has been on Part B Medicare for over twelve months, they are eligible for a medical exam to develop or update a personal prevention health plan. It is designed to prevent further health problems and identify disease risk factors. It is free to the patient. Physicians or other health care providers conducting the exam are reimbursed based on a filed claim. Only one AWV claim is allowed per eligible patient in a twelve-month period.  

Several medical advocacy organizations have received complaints from physicians about third party vendors performing Medicare Annual Wellness Visits (AWV) for Medicare Advantage (MA) plan patients. Some of these third parties use deceptive marketing tactics, such as holding “wellness fairs” to reel in unsuspecting patients, and then submit a bill for the patient’s AWV to the MA plan. They do not tell patients that the screening will constitute their AWV and they will not be able to get their AWV from their regular primary care physician. The patient’s primary care physician may not receive a report of the results of these third-party screenings. Some MA plans are known to contract with third parties for these services to save costs, instead of having AWVs provided by patients’ primary care physicians, who know more about the patient’s medical history and can identify and provide any needed follow-up care.  

Medicare Administrative Contractors (MACs) and MA carriers are all over the board as to how their provider networks can check to see if one of their regular patients has already received their AWV. Consequently, it is not easy to know whether an AWV has been conducted until the carrier denies the AWV claim filed by the patient’s doctor. Neither physicians nor patients know where to turn for help. Resulting problems include:  

- These third parties disrupt continuity of care provided by the patient’s regular doctor.  
- If no report is generated by the third-party screener to the patient’s primary care doctor, undiagnosed conditions requiring treatment plans or additional diagnostic work-ups cannot take place in a timely manner.
• If a patient’s AWV has already taken place for the year, it cannot be repeated by the patient’s doctor without cost to the patient or the doctor repeating the exam without reimbursement.

**Related Statute/Regulation:**
42 CFR 411
CMS Guidance (“Who is Eligible to Provide the Annual Wellness Visit?”)

**Proposed Solution:**

CMS should institute protections for patients that allows only the patient’s established primary care physician to conduct, and bill for, the Medicare annual wellness visit. CMS should also promulgate a rule that prohibits MA plans from contracting with third-party screeners to conduct AWVs.

CMS should clarify that primary care physicians are the only clinicians that can conduct and bill for Medicare annual wellness visits.
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Short Description: The current statutory requirements governing Medicare telehealth coverage and reimbursement create barriers for physicians and patients. Amending these statutory restrictions and expanding the use of telehealth in Medicare can help improve beneficiary access to critical services, reduce unnecessary hospitalizations, and lower Medicare spending.

Summary: Physicians, including PAI members, have been able to successfully use telehealth to provide critical services to their patients, particularly those in rural areas. In the Medicare program, however, there are statutory restrictions that limit where and how physicians can provide telehealth and receive reimbursement for these services. PAI believes these statutory restrictions should be amended in light of the high-value, low-cost care that can now be delivered virtually.

PAI supports provisions in the 21st Century Cures Act that directed CMS to study whether certain types of Medicare beneficiaries and certain services are particularly suitable for telehealth, and to identify barriers for expansion. In line with these goals, PAI urges Congress to consider statutory changes that would remove several of the location and service-based restrictions that impede physicians from using telehealth more broadly for their Medicare patients. These statutory changes would particularly help physicians and patients in rural states and improve their access to critical services such as high technology monitoring and virtual consultations. Expanding the use of telehealth also has the potential to reduce emergency room visits, hospitalizations and readmissions, which would reduce spending for both beneficiaries and the Medicare program.

Related Statute/Regulation: 42 USC 1395m

Proposed Solution: Amend the Medicare statutory provisions to provide that Medicare-covered services are presumed covered when delivered by telehealth, unless HHS determines that such coverage is inappropriate on a case-by-case basis.
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Short Description: Personal identification information for physician office staff for purposes of physician enrollment

Summary: The CMS enrollment form required for a private practicing physician to participate in Medicare asks the physician to provide the social security numbers and home addresses for their office staff. Without this information, the form is deemed incomplete. Private payers are following suit, creating a significant threat to the security of these individuals’ personal information.

These office staff do not have any ownership interest in their employer’s business. They are not at liberty to make financial decisions on behalf of the physician. With rising incidence of identity theft and database security breaches, employers and employees are extremely cautious about disclosing personal information to third parties. This seems overreaching and invasive.

Related Statute/Regulation: CMS Form CMS855i

Proposed Solution: Eliminate fields for sensitive personally identifiable information for physician office staff.