GOVERNMENT RELATIONS

HBMA
HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

update

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# HBMA Government Relations Committee Annual Federal Advocacy Trip Update

The HBMA Government Relations Committee held its annual federal advocacy trip between June 20 and 22. This visit features a day of meetings at the Centers for Medicare and Medicaid Services (CMS) headquarters in Baltimore, Maryland as well as a day of meetings in Washington, D.C. split between a visit to Capitol Hill and a roundtable discussion with fellow industry stakeholders.

HBMA GR Committee members and staff pose for a picture at the end of a long day!

These trips are a unique opportunity to discuss important policy issues that affect how the healthcare revenue cycle management (RCM) industry interacts with the Medicare program on a day-to-day, operational level. These meetings also include a discussion of broader and more long-term topics as well.

The meetings are not just HBMA asking for changes to Medicare policy. The visits are an important opportunity to establish HBMA as a resource to policy makers. Having held these meetings every year for over a decade, HBMA has made consistent progress in how we actively serve as a resource to federal policy makers.

This all comes down to building relationships with the offices we meet with. HBMA focuses on being honest brokers of information and a trusted voice for how Medicare policy affects the healthcare system. Policy makers acknowledge that despite their best efforts, they often cannot see below the "30,000 foot" level of a policy's impact. They look to HBMA for an on-the-ground perspective that they do not have.

Often times, policy makers will pass a new law or regulation that achieves financial savings or an easing of administrative burdens in one place but fail to realize how this policy might actually increase costs and administrative burdens elsewhere in the healthcare system. This is not due to incompetence or naiveté, but rather due to the fact that the healthcare system is incredibly massive and complex. It is difficult to see how each "move" influences the entire chess board. These policy makers are always eager to meet with us to hear how their work is impacting providers, patients,

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and everyone in between. They are generally open to making changes and improvements where we identify challenges and shortcomings.

The Government Relations Committee also used this opportunity to emphasize HBMA's name change and rebranding as the Healthcare Business Management Association. Many of the topics we discussed went beyond the traditional claims processing and revenue cycle management operations. Medicare reimbursements are increasingly being tied to quality and cost of care. This has reshaped the services healthcare RCM companies provide to our clients. This also serves as another way for HBMA to be a resource to policy makers.

The entire HBMA Government Relations Committee participated in the visits including Government Relations Committee Chair Jackie Willett, and Vice Chair Don Rodden. The other Committee member participants were Sherri Dumford, Holly Louie, Lonnie Johnson, Dave Nicholson, and Arthur Roosa. Also attending was the Committee's newest member, Matthew Albright. Matthew previously worked at CMS, and met with the HBMA Government Relations Committee during past annual CMS visits. HBMA President Michelle Durner joined the Committee for the CMS portion of the trip. HBMA Executive Director Andre Williams, HBMA Director of Government Relations Bill Finerfrock, and Government Relations Associate Matt Reiter, also participated.

This year's visit was the first without Dr. Bill Rogers organizing the meetings for us from within CMS. Dr. Rogers retired from CMS in early 2017. As Director of the Physician Regulatory Issues Team (PRIT), Dr. Rogers helped organize the first HBMA visit to CMS and was instrumental in strengthening the annual meeting to what it is today. As a token of our gratitude, HBMA awarded Dr. Rogers our prestigious Lifetime Achievement Award in 2016 for all of his efforts to help HBMA over the years.

This year's meetings were organized by Dr. Rogers' successor, Dr. Gene Freund. HBMA knows Dr. Freund well. He has been with the PRIT for several years, and plays an active role in facilitating the monthly CMS "First Friday" stakeholder outreach meetings. While Dr. Rogers was surely missed, the attendees were certainly in good hands with Dr. Freund, who found the day of meetings incredibly helpful for his own work.

After a day at CMS, HBMA met with staff for the House Ways and Means Committee on Capitol Hill. HBMA was scheduled to meet with staff for the Senate Finance Committee, but unfortunately this meeting had to be postponed because HBMA's visit happened to coincide with the public release of the Senate's legislation that would repeal and replace the Affordable Care Act (ACA). HBMA was scheduled to meet with one of the lead staff members on that bill, though she was briefing Senators on the newly released bill, and was unable to meet with the Government Relations Committee. HBMA rescheduled that meeting to take place via conference call.

HBMA also facilitated a meeting with other industry stakeholder organizations that we view as strategic partners on many policy initiatives. This meeting brought the American Medical Association, the Medical Group Management Association, the Radiology Business Management Association, the Workgroup for Electronic Data Interchange, and the Healthcare Administrative Technology Association into the same room to discuss opportunities for collaboration on policies of mutual interest.

Toward the end of 2016, the Government Relations Committee developed a strategic plan for 2017 with many priorities likely to carry over into future years. The strategic plan outlines key initiatives for the committee beyond its normal functions of monitoring and responding to important regulations and legislation. These initiatives include a focused effort on:

- improving development and enforcement of HIPAA Administrative Simplification electronic standard transactions;
- improving EHR interoperability; and
- increased collaboration with other industry stakeholders.

On the afternoon before the CMS meetings, the Government Relations Committee met in Baltimore to finalize its preparations. This included discussing how to incorporate the strategic plan into each of the dozen meetings scheduled for the trip. As always, the meetings are a chance for HBMA to find new ways to collaborate with CMS, Congress, and fellow stakeholders. HBMA has been invited to participate in stakeholder feedback groups with CMS, and has testified before regulatory bodies such as the National Committee on Vital and Health Statistics (NCVHS)—most recently on Health Plan ID implementation. Additionally, HBMA has provided feedback to key Congressional Committee offices on legislative initiatives. HBMA also has collaborated with other stakeholders in the past on advocacy goals.

These types of opportunities will continue, but it is always important to find new opportunities to have a seat at the table.

HBMA is pleased to provide a summary following these meetings. If you have any questions about the HBMA CMS/Capitol Hill visit initiative, purpose, or value, please do not hesitate to contact Bill Finerfrock, HBMA Director of Government Relations, or Andre Williams, HBMA Executive Director.

## HBMA COMPLIANCE CONFERENCE CAPITOL HILL MEMBER FLY-IN

Rather than trying to meet with all 535 Senators and Representatives, the Government Relations Committee focused on meeting with the Congressional Committees with jurisdiction over Medicare policy. Almost all legislation that impacts the Medicare program flows through two or three key committees in each Chamber. Targeting these committees is the most efficient way to use our influence.

The policy topics for the meetings were part of the HBMA Government Relations Committee Strategic Plan. These meetings were also an opportunity to build relationships with Congress, strengthen the HBMA brand on Capitol Hill, and educate members on the RCM industry.

The meetings featured policy discussions on the need for Congress and the Federal Agencies to take HIPAA Administrative Simplification more seriously. It has been almost 21 years since HIPAA was enacted and the RCM industry has yet to realize many of the efficiencies that the Administrative Simplification section of the law promised.

The privacy and security sections of HIPAA have been heavily enforced. Reports of financial settlements with covered entities for HIPAA privacy and security violations happen on an almost weekly basis. These settlements generally exceed fines in excess of $1 million. HBMA would like to see similar enforcement for Health Plan violations of standard electronic transactions.

**HBMA believes that CMS clearly has the authority from Congress to enforce financial settlements and penalties for HIPAA Administrative Simplification violations. HBMA wants CMS to use this authority.**

However, HBMA leadership decided to expand our advocacy footprint in 2017 by conducting more grassroots-style outreach to Capitol Hill. One month prior to the annual Government Relations Committee visit, HBMA facilitated an opportunity for HBMA members to contribute towards HBMA's federal advocacy efforts. The 2017 HBMA Compliance Conference was held just outside of D.C. in Alexandria, Virginia. HBMA incorporated an advocacy day on Capitol Hill for interested HBMA members into the Compliance Conference program.

HBMA arranged for those volunteers to meet with their House Member and Senate offices. Attendees were given a presentation on how to lobby and were also provided leave behind materials and talking points for their meetings. About 20 HBMA members representing companies from all parts of the country participated in the fly-in.

HBMA would also like to see an expedited development and implementation of new standards such as claims attachments. Other standards could also be improved. For certain standards such as claims status, Health Plans comply with the technical aspects of the standard, but the information is vague and not useful to the provider.

HBMA members are often responsible for developing technical and operational workarounds for ineffective or non-existent transaction standards for our clients. This adds an incredible amount of administrative and financial burden.

The Congressional offices were generally very receptive to this message. They recognize how improving the efficiency of the healthcare system with better standardized electronic transactions can save the system billions of dollars. Several offices

expressed interest in working with HBMA to see what more can be done to improve HIPAA Administrative Simplification.

Some attendees shared statistics from the annual CAQH CORE Index report, which provides statistics on electronic transaction adoption. The report also estimates the cost savings that could be achieved by adopting electronic transactions. This report resonated with the offices that were presented with its findings.

Despite some mixed messages that we have received from CMS in the past, HBMA believes that CMS clearly has the authority from Congress to enforce financial settlements and penalties for HIPAA Administrative Simplification violations. HBMA wants CMS to use this authority. This makes our "ask" of Congress much simpler, since we are not requesting new legislation.

Congress has many non-legislative options for pursuing agency action. Individual members can write letters or make phone calls to CMS. Committees can also include report language with legislation. Bill reports accompany legislation and are used to clarify Congressional intent. Report language does not carry the force of law, but it can be incredibly influential. It is considered a "warning shot," which could lead to more formal legislative efforts if the agency does not act according to Congressional intent.

The HBMA Government Relations Committee intends to follow up with the offices that were most interested in this issue with the goal of non-legislative action to encourage CMS to use its existing enforcement authority.

The attendees also discussed the prevalence of health plans with overly narrow networks. These plans can have a detrimental effect on patient access to care. Further, there needs to be better transparency, since networks can change throughout a patient's plan year.

HBMA believes that if a health plan makes a change in the plan network after the close of the open enrollment period, and physicians and hospitals previously identified as "in-network" are no longer in the plan's network, patients affected by that plan decision should be permitted to re-enter the marketplace to choose another plan.

Kim Glaun, Medicare-Medicaid Coordination Office (MMCO) – Dual-Eligible Beneficiary Policies

Finally, these meetings are intended to establish HBMA as a resource to Congressional offices as they engage in the policy making process. The ultimate goal is for Congressional offices to be able to proactively reach out to HBMA for input as they draft legislation. This involves educating members on our industry's role in the healthcare system. It also means conducting consistent outreach to brand HBMA as a trusted and useful broker of information.

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HBMA is greatly appreciative of the attendees who donated their time to represent our industry at this important event.

HBMA hopes to continue its grassroots advocacy efforts including holding this member fly-in on a regular basis. The HBMA Government Relations Committee plans to follow up with the offices that express significant interest in our issues.

## MEETING WITH MMCO

The Medicare-Medicaid Coordination Office (MMCO) was not initially on our schedule. It was added at the request of Kim Glaun of the MMCO staff. Kim wanted to share the work MMCO is doing on behalf of dual-eligible beneficiaries, specifically regarding the Qualified Medicare Beneficiary (QMB) program. There are currently 7.2 million QMBs.

QMBs are exempt from the Medicare cost-sharing obligations. However, providers do not always receive accurate information from the patient regarding their QMB status leading to inadvertent billing for cost sharing, which is prohibited for QMBs.

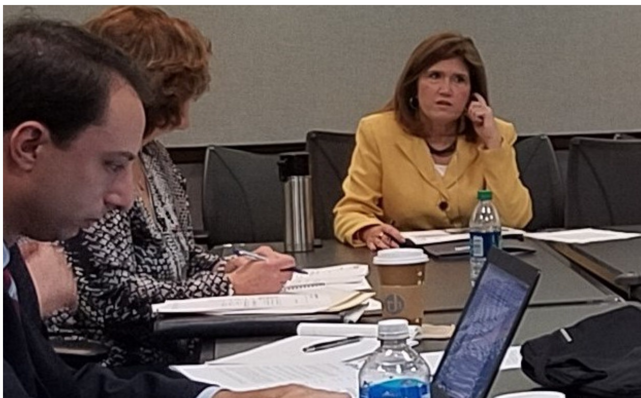
CMS has been trying to improve outreach and education to providers regarding QMBs. CMS is also trying to improve the way QMB status is communicated to provider offices. In the meeting, CMS shared with us that Medicare summary notices will tell patients of their QMB status. CMS is also incorporating Claims Adjustment Remark Codes (CARCs) and Remittance Advice Remark Codes (RARCs) to help clarify QMB status.

CMS clarified that providers can still bill a state Medicaid program for the balance of a claim on crossover claims, but providers are subject to each state's policy on these claims. The Government Relations Committee mentioned how difficult it can be dealing with Medicaid Managed Care Organizations on crossover claims.

HBMA members have experienced difficulties with crossover claims to Medicaid programs in states that use Managed Care Organizations in place of a state-run program. According to CMS, every state except South Carolina has a coordination of benefits agreement (COBA) by which Medicaid Managed Care Organizations (MCO) should be able to accept crossover claims.

MCOs are supposed to sign COBAs but many do not. CMS acknowledged the lack of enforcement.

The Government Relations Committee encouraged CMS to increase enforcement and levy fines and civil monetary penalties if necessary. As of October 1, Medicare's HIPAA Eligibility Transaction System (HETS) will show QMB status. CMS will be announcing this update in the next few weeks and will be providing education to providers after the announcement.



Melanie Combs-Dyer, Program Compliance Group – Navigating the CMS Program Integrity Architecture

The Government Relations Committee recommended that CMS develop an FAQ on these changes. CMS liked this idea and promised they will look into producing an FAQ. The Government Relations Committee also suggested hosting a webinar for the HBMA membership, in which someone from CMS would present on these changes. Gene Freund also invited them to speak at a monthly CMS education meeting he facilitates for industry stakeholders.

This meeting truly speaks to the strength of the relationship HBMA has built with CMS. Not only did CMS request this meeting with HBMA, the meeting resulted in new opportunities to collaborate with CMS. It also was clear that CMS was receptive to HBMA's ideas for improving education on this issue.

## MEETING WITH PCG

The Government Relations Committee's meeting with Melanie Combs-Dyer, director of the Provider Compliance Group (PCG), was particularly informative and helpful. The PCG is within the Center for Program Integrity (CPI). Melanie gave a presentation on what the PCG and other groups under the CPI are working on before spending time discussing the issues the Committee identified as discussion topics.

It was an honest and informative session that proved how HBMA is viewed as a trusted partner for CMS. Melanie was very receptive to the Government Relations Committee's recommendations and is interested in finding ways to make some of our suggestions a reality.

Most of Medicare's program integrity work is delegated out to contractors. There are many types of program integrity contractors, each with a different purpose and authority. One of Melanie's main job functions is to manage some of these contractor programs. Melanie's presentation clarified how CMS organizes its contractor programs, including the specific roles of each contractor program and the boundaries for each contractor-type.

In total, the CPI estimates that there is $41 billion in improper Medicare fee-for-service payments. Over half of this estimated amount is from Part A facilities such as home health agencies

(HHA), inpatient rehabilitation facilities (IRF), outpatient hospitals, and skilled nursing facilities (SNF). Only $4 billion of this estimate is from traditional inpatient hospitals.

According to estimates, CMS believes that the HHA improper payment rate is as high as 42 percent and the IRF improper payment rate is as high as 73 percent.

CMS believes this shows a need to better educate providers on the billing rules. It also could mean that some providers are deliberately cheating the system. Congress and watchdogs are quick to attribute the entirety of the estimated improper payments to fraud. However, CMS makes a distinction between deliberate fraud and failure to understand the rules. CMS also points out that underpayments are included in the improper payment estimates – although, CMS estimates the ratio of overpayments to underpayments to be nine to one.

Common reasons for overpayments include billing for excluded or non-covered services, billing for medically unnecessary services, and billing for services furnished in inappropriate settings.

The PCG oversees the program integrity efforts of Medicare Administrative Contractors (MAC) and Recovery Audit Contractors (RAC).

MACs have a limited program integrity authority. MACs can only perform a basic level of front-end claims edits and conduct provider enrollment screening. RACs are able to conduct post-payment reviews of claims and request supporting documentation. RACs can also recoup overpayments and compensate providers for underpayments.

The PCG spoke of how it tries to educate providers before enforcing corrective action. The PCG can also provide education to providers who are inaccurately billing Medicare to try to correct the problem before a contractor gets involved.

For the providers it targets, PCG directs MACs to review a small handful of claims. If there are errors, the MACs are supposed to conduct several rounds of education before attempting to take corrective action. If errors go unresolved, MACs can elevate these providers to other contractors such as RACs, Zone/Unified Program Integrity Contractors (Z/UPIC), or even the Department of Justice (DOJ).

The PCG is trying to improve upon these processes to avoid the need for corrective action. CMS is encouraging MACs to review a larger sample size of claims to determine if education is needed. MACs are also directed to conduct three rounds of education before elevating the issue to other contractors.

The PCG is also trying to target their efforts to bad actors. They are currently paying a lot of attention on HHAs and other facility-types with high estimated improper payment rates. CMS is also encouraging MACs to focus on new providers who might be unfamiliar with the billing rules.

The PCG also manages Supplemental Medical Review Contractors (SMRC). These contractors are told where to conduct document requests and audits by the PCG itself. Government Relations Committee member Holly Louie made a recommendation to CMS on how to improve the operational process of SMRCs. When conducting a review, under current policy, SMRCs send requests for documentation to a provider's practice address listed in PECOS. For provider-based specialties, the practice address is often a large hospital where these document requests are likely to get lost in the mailroom and never make it to the provider.

Holly recommended that SMRCs send documentation requests to the correspondence address (which is often the RCM company) to ensure that it is actually received. CMS acknowledged this issue and promised to make that change. CMS was honest that it might take several months before the change takes effect and asked HBMA to follow up with CMS to make sure the change is made.

This is a true testament to the progress HBMA has made through this annual visit to CMS. Attendees recalled many past meetings from the initial years of the visit in which the CMS staff took a more adversarial, or distrustful tone. Now, the CMS staff is eager to hear HBMA's ideas on how to improve their operations. They are often willing to consider our suggestions where it makes sense, but they are also honest with us if they do not believe a suggestion can be implemented. The Government Relations Committee obviously prefers when CMS is open to our suggestions, but we still appreciate the amount of honesty we receive when CMS disagrees.

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## MEETING WITH RAOD

After the Provider Compliance Group, the attendees met with Brian Elza, director of the Recovery Audit Operations Division,

which oversees the Recovery Audit Contractor (RAC) Program. Brian provided the group with an update on the new contracts that were just awarded at the end of 2016, as well as the closing out of some old contracts that expire in January. Brian also updated the group on improvements he is making to the RAC program.

There is currently a massive backlog of appealed RAC determinations. HHS has hundreds of thousands of pending appeals cases but only has the resources to handle a fraction of the total caseload per year. Congress is working to provide HHS with additional resources to deal with the appealed claims. However, CMS is actively trying to take measures to reduce the amount of appealed RAC determinations on its own.

One example of this effort is a new discussion period, which CMS facilitates between the RAC and the provider to allow the provider to fix errors on claims. This is intended to prevent the need for an appeal in between a denial and a correction. Often times, by the time a denied claim is overturned on appeal, it is beyond the one-year timely filing period to resubmit the claim. In order to promote efficiency during the discussion period, Brian's office is working to introduce a new timeline by which RACs must reply to providers during the discussion period. This also prevents RACs from procrastinating and waiting out the discussion period.

The Government Relations Committee expressed its appreciation for CMS' efforts to allow claims to be fixed and resubmitted, to ultimately avoid the need for a burdensome appeal. The Committee also acknowledged how CMS is attempting to account for ways an RAC could skirt the system, such as by waiting out the discussion period.

HBMA expressed our desire to see the past timely filing regulations officially changed to allow successfully appealed claims to be resubmitted beyond the one-year timely filing deadline. Brian agreed that this change would be helpful. He told our group that he has tried to make such a change, but he has not been successful.

He is trying to make similar improvements, such as limiting the RAC lookback period to six months for hospital inpatient status claims, with the goal of resolving these appeals quickly enough to allow enough time for a resubmission.

Brian noted that RAC performance is evaluated by a separate contractor. RACs must have a 95 percent accuracy rate. According to Brian, RACs generally have an accuracy rate between 90 and 95 percent, but it is often higher than 95 percent. Brian's office is trying to incentivize accuracy by awarding higher contingency fees for low overturn rates.

Additionally, Brian's office is trying to separate the bad actors from the rest of the provider community. Home Health Associations (HHA) and Durable Medical Equipment (DME) providers have recently had higher rates of improper payments. All HHA and DME providers have been placed into their own RAC jurisdiction. This is consistent with what Melanie Combs-Dyer from the Provider Compliance Group shared with us.

The Government Relations Committee asked if there is anything our organization could do to help make his life easier. We discussed the subjectivity of some coding scenarios, especially with Evaluation and Management (EM) codes. There is often a gray area between Level 1, 2, and 3 EM codes. Brian indicated that he is directing RACs to focus on

Brian Elza, Division of Recovery Audit Operations – Targeting RAC Audits

more egregious coding discrepancies, such as a Level 4 or Level 5 EM claim that should be a Level 1, rather than focusing on these gray area scenarios. However, he is also working to add clarity to the gray areas.

The Government Relations Committee also requested that rather than deny an incorrectly billed EM claim, CMS should just pay the claim at the level it should have been billed. Brian stated that he is working with the contractors to incorporate this type of practice.

Finally, Brian mentioned that most of what the RACs are finding are not new practices. RACs are mostly finding the same improper billing practices as they always have. Further, most of the errors they find are due to a lack of documentation.

The attendees were very appreciative of Brian's honesty and his openness to our ideas. There was considerable agreement between the two sides of the table. However, both parties agreed that more can be done.

## MEETING ON MEDICARE PART C

Traditionally, the HBMA Government Relations Committee only schedules meetings with CMS offices with jurisdiction over Medicare Part B. Due to an increase in membership complaints regarding Medicare Part C issues, the Government Relations Committee decided to include a meeting on Part C issues.

CMS divides its oversight authority for Part C, also referred to as Medicare Advantage (MA), across three divisions. The attendees met with the director, Vikki Ahern, who oversees all three. Vikki shared with us some background on the jurisdiction of each of the three divisions. This background will help the Committee identify which Part C office in CMS to direct its questions to in the future.

The discussion featured issues that range across all three of these divisions. Network adequacy was a key discussion topic. The Government Relations Committee raised concerns over the size of MA plans. However, the real issue is the accuracy of network directories. CMS is well aware of these problems. Vikki told the group that CMS has been conducting audits of MA plan directories. CMS is also working to strengthen network adequacy requirements for MA plans.

Vikki Ahern and Trish Axt, Director Medicare Parts C and D Oversight and Enforcement Group – MA Compliance

If anything, CMS is concerned that it might not be conducting enough audits. CMS is conducting as many as they can with the resources they are given. It was reassuring to hear that CMS is aware of this issue and committed to addressing these concerns.

CMS highlighted how, in addition to audits, they have levied civil monetary penalties (CMP) on plans for various types of violations. The largest CMP to date on a plan has been $3 million. Additionally, CMS went as far as to impose a marketing and enrollment ban on Cigna's MA plans in January 2016. The ban was lifted earlier this month after corrective action was taken.

CMS also discussed the resources that are available via the CMS Health Plan Management System (HPMS).

The Government Relations Committee mentioned how RCM companies can often avoid an MA plan's training requirements but there are still some cases where they cannot. CMS has been taking steps to reduce the training burden for first tier, downstream, and related (FDR) entities such as RCM companies.

The Government Relations Committee discussed how CMS can better educate stakeholders on these types of important changes. CMS suggested publishing information in new forums. Dr. Freund suggested incorporating this as a topic in his monthly stakeholder education and outreach meetings. Tying the conversation back to the Government Relations Committee's Strategic Plan, the group asked CMS if there is a streamlined way to file HIPAA Administrative Simplification complaints for MA plans. According to CMS, there is no such mechanism. Complaints for MA plans must go through the normal complaint process.

The Committee found that meeting with the Part C staff was a useful allocation of our limited time with CMS. Based on Vikki's description of the CMS internal structure for managing Part C issues, it seems like the Committee could spend an entire second day at CMS just meeting with all of the Part C offices. It is likely that the Committee will request meetings on Part C issues going forward, although the schedule will continue to focus predominantly on traditional Medicare Part B issues.

John Pilotte and Dan Green, MD, Performance-based Payment Policy Group – Transitioning to MIPS

## MEETING WITH PPG

The Government Relations Committee's meeting with the Payment Policy Group was among the most pertinent of the schedule. This office is responsible for much of the Medicare Quality Payment Program (QPP) and some of its predecessor quality reporting programs that now make up the Merit-based Incentive Payment System (MIPS) within the QPP. CMS published the proposed rule for the 2018 QPP reporting year the evening before the Government Relations Committee's meeting with CMS.

2017 is the first reporting year for MIPS. However, CMS is still adjusting Medicare payments based on reporting under the Physician Quality Reporting System (PQRS) and the Value-based Modifier (VM) for data reported in 2015 and 2016. PQRS and the VM make up the quality and cost categories in MIPS, respectively, with some important changes.

HBMA was first given a brief update on these legacy reporting programs before the conversation turned toward the future of those programs in MIPS.

Perhaps the most significant item to note about the old programs is that many clinicians still do not participate. For example, in the 2017 payment year, about a third of clinicians will receive a downward payment adjustment for failing to report data under the VM program. Many of these clinicians see so few Medicare patients that it is not worth it for them to invest the resources necessary for participating in these programs. This will change under MIPS since the negative payment adjustments for failure to report will increase substantially.

As mentioned before, the CMS proposed rule which presents changes to the 2018 reporting year for the QPP was released the evening before the Government Relations Committee's meetings at CMS.

Members of the Committee were able to perform enough of a review of the 1,000-plus page document in advance of the meeting to allow for a helpful discussion with the Performance-based Policy group.

CMS recognizes that HBMA can be a beneficial partner in educating providers about the QPP. CMS understands that RCM companies often provide QPP-related services to clients. The attendees discussed how HBMA is taking an active role in educating its members on the QPP including the ongoing work of the HBMA MIPS Committee. Both the Government Relations Committee and CMS agreed that it would be helpful for CMS to participate in some educational programs for our members once the Committee has had a chance to perform a more diligent review of the proposed rule.

CMS is also facilitating focus groups of providers to obtain feedback on how to improve MIPS. The Government Relations Committee expressed our desire to participate in similar focus groups if they are expanded to administrative groups.

According to John and Dan, CMS has invested significant resources into its help desk for troubleshooting questions on MIPS. The Government Relations Committee asked if it would be possible to create a direct pipeline for HBMA members to submit questions on MIPS to the second- or third-tier levels. RCM companies often ask complex questions that the first-tier help desk staff are unable to answer, requiring the issue to be elevated to subject matter experts. This adds to the time it takes to receive a response.

CMS acknowledges that our questions often rise above the expertise of the first-tier help desk staff; however, CMS intentionally filters all questions through this system in order to track all of the questions they are receiving. This will help CMS identify persistent issues that might require additional education. CMS expressed confidence in its help desk system for MIPS and that it will efficiently provide answers.

HBMA management plans to follow up with CMS to discuss hosting webinars and other educational partnerships.

## MEETING WITH NSG

Earlier this year, the Government Relations Committee welcomed Matthew Albright as a new member to the Committee. Matthew previously worked at CMS in what is now called the National Standards Group. In that position he represented CMS at several of the annual HBMA Government Relations Committee visits to CMS headquarters. This year, he was on the other side of the table representing HBMA before some of his former colleagues.

The National Standards Group (NSG) is the office in CMS responsible for HIPAA Administrative Simplification standard

Christine Gerhardt, Program Management and National Standards Group – When Will Administrative Simplification Have its Day in the Sun?

electronic transaction compliance. Advocating for stronger enforcement of HIPAA Administrative Simplification violations is a key initiative of the Government Relations Committee's strategic plan. HIPAA was signed into law almost 21 years ago and the industry has yet to realize much of the administrative simplification the law was intended to create.

The Government Relations Committee expressed HBMA's strong desire for improved enforcement. HBMA identified issues and areas for improvement throughout the entire chain of the complaint process.

First off, it is very difficult to file a HIPAA violation complaint to CMS. Submitting a complaint **electronically** requires the complainant provide CMS with extensive personal information including social security number. The irony was not lost on the CMS attendees when we explained that it is easier to submit complaints by paper than it is electronically. Although paper complaints are easier to submit, they are impossible to track and often lead to errors in the response from CMS.

Issues continue after a complaint makes it into the pipeline. Even though the complaints are supposed to be anonymous, once a health plan is given an opportunity to respond, the complainant is often required to provide supporting material including names and other information, which defeats the purpose of anonymity.

Finally, if CMS decides that a complaint is valid, it does not levy penalties against a health plan for the violation. There is also no accountability for timely corrective action. During the 2016 CMS visit, the Government Relations Committee was told that this is because CMS does not have the authority to negotiate financial settlements with health plans. That official claimed CMS had the authority to levy civil monetary penalties (CMP) which, if applied, would be an excessive punishment for the violations.

HBMA Government Relations staff looked into this supposed lack of legal authority to negotiate financial settlements that are less punitive than CMPs and concluded that the legal authority for negotiating financial settlements is rather clear. The Committee raised this with CMS during this year's visit. The NSG, which came under new leadership between last year's visit and this year's visit, agreed with HBMA that it has the authority.

The HHS Office of Civil Rights (OCR), which is responsible for enforcing HIPAA Privacy and Security violations, regularly issues negotiated financial penalties for privacy and security violations. HBMA would like CMS to take similar actions for Administrative Simplification violations.

The Government Relations Committee shared with CMS that while we support negotiated financial settlements over CMPs, we are less concerned with the specific type of financial punishment. It is our belief that the first financial penalty will serve as a wakeup call to all health plans to start taking electronic transaction standards seriously.

The NSG shared with us that CMPs are still under consideration but there are no detailed proposals to begin levying CMPs or negotiated financial penalties at the moment. While NSG agrees that the authority for levying penalties exists,

Larry Young, Rich Cuchna, and Pat Payton, Medicare Contractor Management Group – Improving Interactions with MACs.

imposing a CMP is considered a regulatory burden on industry.

Earlier this year, President Trump signed an executive order intended to reduce regulatory burdens on industry. This executive order requires CMS to identify two regulations to eliminate for every new regulation it seeks to impose. CMS maintains that this will make it difficult to impose a CMP due to its classification as a "regulatory burden." It is therefore difficult to impose CMPs, which are considered a regulatory burden.

NSG did say that they expected to announce a pilot project this summer on an audit program. NSG expressed that they will continue to look for ways to improve enforcement of HIPAA Administrative Simplification provisions and hope to continue working with HBMA to identify ways to strengthen this process.

The Government Relations Committee also discussed our desire to see overdue standards such as claims attachments adopted into use. NSG is continuing its work to develop claims attachment standards, but no regulation implementing claims attachments is expected any time soon. According to CMS, implementing new standards would also be considered a regulatory burden which would require identifying two other regulations to eliminate.

CMS is collecting data to prove that claims attachments would actually lead to cost savings across the industry. If successful, this could lead to the new standards no longer being considered a regulatory burden.

CMS suggest that HBMA could help collect data from our membership to help justify that claims attachment standards would create cost savings across all areas. The Committee expressed a strong interest in working with CMS to help provide data to achieve this goal. This is a perfect example of how HBMA can serve as a resource to policy makers.

Finally, the NSG reiterated to the Committee that HBMA is viewed as a partner to CMS. Several months ago, HBMA facilitated a site visit for NSG staff to learn about the "life of a claim." NSG staff visited a radiology practice's administrative office, as well as an HBMA member company's office, to learn about the full life cycle of a claim from patient encounter to payment. The NSG staff who attended found it to be an incredibly valuable experience. The NSG staff shared this with the NSG leadership, who again thanked the Committee for the opportunity during the meeting.

The meeting concluded with an agreement to continue following up with NSG on these important issues.

**NSG expressed that they will continue to look for ways to improve enforcement of HIPAA Administrative Simplification provisions and hope to continue working with HBMA to identify ways to strengthen this process.**

## MEETING WITH MCMG

The Medicare Contractor Management Group (MCMG) oversees the day-to-day functions of how clinicians and their partners interact with Medicare Administrative Contractors (MAC). This includes the MAC self-service portals, the MAC call centers and customer service centers and many associated CMS.gov webpages. They are also responsible for publishing the MLN Matters educational material for stakeholders.

CMS highlighted several improvements it has made to the MAC program since the Government Relations Committee began holding this annual meeting over a decade ago. HBMA

has long-complained to CMS about inconsistent responses from help desk staff across MACs.

CMS is aware of this problem and has been taking steps to improve MAC responses. According to CMS, MACs now have a 97 percent accuracy rate based on third party contractor reviews of MAC help desk calls.

CMS also clarified its rationale behind its decision to limit how many claims a caller can discuss on each call to a MAC's help desk. This limitation has frustrated HBMA members as we often have many questions we wish to discuss with MAC help desk staff. Limiting how many claims can be discussed greatly adds to the time and resources it takes to get the information we need.

According to CMS, this policy is in response to a handful of callers who regularly dominate the phone lines. CMS believes these callers are most likely from an off-shore company and appear to have very limited knowledge of the Medicare billing process. It was rather clear to CMS that these callers were reading off of a script and were asking about identical issues for each claim on their very long lists. The callers did not extrapolate that an answer to their question on the first claim is the same answer for the same question on every other claim.

CMS has already identified one billing company associated with an off-shore company that is a major contributor to this issue.

HBMA had complained to CMS in past meetings about this limitation. This clarification was very helpful in understanding CMS' rationale, but the Government Relations Committee still requested a way around this limitation.

CMS expressed that little can be done. CMS is hoping that improved education on available resources and how to best utilize MAC help desks will be the answer to reducing these high-frequency callers. CMS is also trying to deal directly with these offenders and the providers they represent to end these abuses.

The Government Relations Committee indicated that HBMA would be willing to help CMS distribute educational material to our membership.

CMS also shared with the group that CMS is no longer pursuing MAC jurisdiction consolidations. CMS does not want to make the MACs so large that they cannot be "nimble" and also wants to maintain jurisdictional competition.

The Government Relations Committee also discussed how crossover claims can cause major headaches. CMS acknowledged the difficulties crossover claims can pose even though their data shows that 98 percent of crossover claims are handled successfully. The two percent that are unsuccessful are usually because of a HIPAA transaction failure. CMS did agree that MACs should be able to give RCM companies more information on why a crossover claim failed.

CMS discussed how it is piloting a new demonstration through Palmetto to furnish comparative billing reports (CBR) to providers. These reports will share how a provider's billing trends compare to that of their peers. CMS hopes to expand this pilot to all MACs in the future.

The Government Relations Committee was aware of this demonstration and shared with CMS that it is difficult to make use of these reports. Each practice is very different from each other and it is difficult to apply the data to each practice. HBMA recommended that CMS should target the CBRs to only the providers who are the most egregious outliers.

The Committee also raised that CMS needs to reduce the letters it sends to providers for retroactive corrections. CMS currently sends a letter for each claim, which can result in an unnecessary amount of notifications. The Committee recommended that CMS send one notification letter per TIN as opposed to one per claim. CMS agreed with this recommendation and will explore such a change.

Finally, the discussion turned to the Social Security Number Removal Initiative (SSNRI), which statutorily requires CMS to remove Social Security Numbers (SSN) from Medicare beneficiary cards. CMS is in the process of switching from SSNs – also called the Health Insurance Claim Number (HICN) – to a new, unique Medicare Beneficiary Identifier (MBI) number.

CMS asked the Government Relations Committee if HBMA members will have issues with the new MBI numbers. The Committee shared its concerns about replacing SSNs because this is often the easiest, if not the only way to identify a patient.

CMS has been providing industry with regular updates on how it will transition to the new MBI number. CMS reminded the group that it will soon start using MBIs instead of HICNs on remittance advice.

Mark Majestic, Investigations and Audits Group – Focusing ZPIC/UPIC Efforts.

## MEETING WITH IAG

The Government Relations Committee's conversation with the Investigations and Audit Group featured many familiar topics from past meetings. The Committee met with the group's director, Mark Majestic, who we have consistently met with for several years. Mark is always open about how much he enjoys meeting with HBMA.

The Investigations and Audits Group (IAG) oversees the Medicare Zone Program Integrity Contractors (ZPIC) as well as the new iteration of the program called the Unified Program Integrity Contractors (UPIC), which consolidates both Medicare and Medicaid jurisdiction under one roof.

The Government Relations Committee had previously held program integrity meetings that focused on Medicare Administrative Contractors (MAC) and Recovery Audit Contractors (RAC). These two contractors make up the lower tiers of program integrity and perform the bulk of the Medicare fraud prevention and recovery functions. ZPICs and UPICs are the highest level of program integrity contractors that handle the worst offenders that cannot be dealt with by other contractors.

ZPIC and UPICs preform pre- and post-payment reviews on some or all claims submitted by the providers that reach this level. Providers who continue to engage in fraudulent billing practices can have their participation in the Federal Healthcare Programs suspended and can be investigated by the Federal Bureau of Investigation (FBI) for criminal prosecution. According to Mark, his goal is for ZPIC/UPIC investigations to lead to either recoupment money or revocation of provider's ability to participate in the Federal Healthcare Programs.

Mark gave the Committee an update on the transition from ZPICs to UPICs. There are currently two UPICs, one in the Midwest and another in the Northeast jurisdiction. A third contract was awarded for the Western jurisdiction, but that award is currently under protest and cannot begin until the protest is resolved. The IAG is hoping to complete the UPIC transition in the near future.

The IAG is very pleased with how the new UPIC program is working out. It has greatly improved the interactions between the Medicare and Medicaid programs. CMS is also taking a proactive role in overseeing the contractors. Previously, the contractors each had their own case management systems that did not coordinate well with each other. Recently, CMS developed and implemented a unified case management system under CMS control which manages each contractor's case load. CMS can also access the system on its own to track each contractor's progress. Prior to the unified case management system CMS had to request this information from the contractors.

ZPICs and UPICs are able to conduct onsite visits and request medical records. Mark has seen these efforts result in significant decreases in Medicare billing in counties where a physical visit has been performed.

CMS has also developed a predictive analytics tool called the Fraud Prevention System (FPS) to help identify bad actors who warrant attention from ZPIC/UPICs. In 2015, the FPS had a return on investment (ROI) rate of about 11:1. CMS is still in the process of calculating the ROI for 2016 so it has not yet been publicly released. However, Majestic told the Committee that the ROI will be consistent with past trends.

All of these efforts are intended to increase ZPIC/UPIC efficiency and to give CMS more direct control over their priorities. CMS is committed to focusing on problematic providers while avoiding the compliant providers who represent the majority of Medicare-billing providers.

IAG is developing strategies for specific provider types that are among the most problematic, such as home health and hospice providers. CMS is also moving away from a complaint-driven approach to a more proactive, data-driven approach.

According to Mark, only 292 individual providers out of the 2 million total providers participating in the Federal Healthcare Programs are currently under prepayment suspension. Half of these are due to law enforcement requests while the other half is from CMS determinations.

## MEETING WITH CCSQ

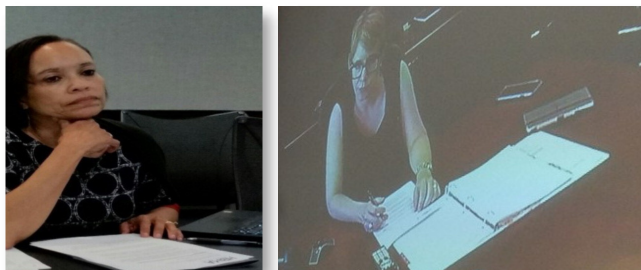
Kate Goodrich and Jean Moody Williams lead the Center for Clinical Standards and Quality (CCSQ), which oversees the rulemaking for the Medicare Quality Payment Program (QPP). The proposed rule for the 2018 QPP reporting year was released to the public only 24 hours before the Government Relations Committee met with CCSQ. The meeting focused almost exclusively on the Merit-based Incentive Payment System (MIPS), which makes up the main participation option of the QPP.

CCSQ provided an overview of the proposed rule to the Committee before taking our questions and asking for feedback on the 2017 reporting year.

The Government Relations Committee expressed to CMS that we are glad CMS is continuing the "pick your pace" flexibilities in 2018. This makes it relatively easy for clinicians to avoid a negative payment adjustment while still providing an opportunity for positive payment adjustments for those clinicians who choose to fully participate for at least 90 days. Clinicians will have to report more data than they do in 2017 in order to avoid negative payment adjustments for the 2018 reporting year. Although the concept will remain, CMS is moving away from the term "pick your pace."

CCSQ reminded the Committee that by the 2019 reporting year CMS is required to use either the median or the mean of composite performance scores to determine the payment adjustments. For 2017 and 2018, CMS sets the benchmark score, which determines the payment adjustments. In 2017, the benchmark score is three, but CMS is proposing an increase to 15 in 2018.

CMS is also allowing clinicians to use multiple reporting mechanisms for each of the four MIPS reporting categories in 2018. Currently, clinicians are limited to using the same reporting mechanism for all data reported in a reporting category.



Kate Goodrich and Jean Moody Williams, Center for Clinical Standards and Quality – Striking a Balance Between Flexibility and Simplicity in MIPS.

Perhaps the most significant proposed change for 2018 is an increase of the low-volume provider threshold. In 2017, clinicians (individuals or groups) who have $30,000 or less in Medicare revenue or who treat 100 or fewer Medicare patients are exempt from MIPS reporting. CMS is proposing to increase the threshold in 2018 to $90,000 or less in Medicare revenue, or 200 or fewer Medicare patients. This will broaden the exemption to thousands of clinicians.

**CCSQ reminded the Committee that by the 2019 reporting year CMS is required to use either the median or the mean of composite performance scores to determine the payment adjustments.**

In general, CMS is trying to create as much flexibility as possible with an emphasis on helping clinicians avoid the MIPS penalties.

The Government Relations Committee shared its appreciation for this flexibility. The Committee also shared some thoughts on how to improve MIPS. First and foremost, the Committee recommended that CMS improve how clinicians receive feedback on their performance. The feedback reports are not frequent enough.

Also, while the feedback reports can give clinicians information on their own reporting, it is difficult for the reports to provide meaningful information on how a clinician's performance compares to their peers. A performance score qualifies for positive payment adjustments by exceeding the

performance threshold but the actual MIPS payment adjustments are based on how a clinician's performance ranks against every other clinician.

CCSQ is actively working to improve the timeliness of feedback data to clinicians. However, CMS will not be able to provide real-time information on how a clinician's performance compares to their peers.

CMS has also begun collaborating with the US Digital Service (USDS) to help develop more useful and user-friendly tools for clinicians. The USDS is part of the Executive Office of the President. Its mission is to help federal agencies deliver better government services to the American people through technology and design.

The Government Relations Committee also inquired about any improvements being made to the help desk. CMS highlighted how it has strengthened its help desk, especially for the types of complex questions HBMA members usually ask. In particular, CMS has improved how questions are handed off from help desk staff to subject matter experts.

CMS is trying to strike a fine balance between simplicity and flexibility. The simpler a program is, the fewer pathways that are available to succeed. The more flexible a program is, the more confusing it is, but there are ideally a greater number of pathways that lead to success. As with every new program, CMS is trying to find the right balance of each.

The Committee cautioned CMS to limit the administrative burden of MIPS as much as possible. There are already concerns among the entire healthcare system that clinicians are spending too much time on administrative functions for quality reporting programs, which is actually detracting from the quality of patient care.

Finally, the Government Relations Committee shared with CMS all of the work HBMA is doing to educate our members, specifically the newly formed MIPS Committee. CCSQ was appreciative of HBMA's education efforts and recognizes that organizations like ours are key to a successful QPP.

## CAPITOL HILL – STRENGTHENING RELATIONSHIPS AND SERVING AS A RESOURCE

The day after the CMS visits, the Government Relations Committee spent the morning on Capitol Hill to meet with staff from key Congressional Committees with jurisdiction over Medicare policy.

The group began the morning meeting with Nick Uehlecke from the House Ways and Means Committee's Health Subcommittee staff. The Committee has met with Nick for several years and has built up a solid rapport. Nick is someone we can rely on for a frank and honest discussion on any health policy topic. Nick is always incredibly interested in our perspective on Medicare policy.

The meetings were coincidentally scheduled for an interesting time to be on Capitol Hill. CMS released the 2018 Quality Payment Program (QPP) proposed rule only two days prior, and the Senate's first version of an Affordable Care Act (ACA) repeal/replace bill was released on the same day as our visit.

The Government Relations Committee's meeting with Nick provided an opportunity for the committee to be one of the first stakeholder groups to share our initial thoughts on the QPP proposed rule with the staff we met with on Capitol Hill. This also allowed the HBMA Government Relations Committee

to hear the perspective of the Ways and Means Committee staff on the proposed rule, which gives the Government Relations Committee an indication of what ideas will resonate with Congress and CMS.

Nick shared with us that the ACA repeal/replace efforts are holding up most other health policy initiatives in Congress. The partisanship of the issue has resulted in less cooperation on traditionally bipartisan topics such as Medicare policy. However, there will be must-pass legislation later this year to reauthorize the Children's Health Insurance Program (CHIP). This bill will most likely serve as vehicle for other health policy provisions.

Nick also informed us that Secretary of Health and Human Services (HHS) Tom Price has made himself very accessible to members of Congress. According to Nick, Secretary Price is taking almost every call he gets from Congress to hear their concerns and ideas for HHS.

There was a lot of agreement between Nick and the Government Relations Committee on the QPP proposed rule. Similar to HBMA, Nick was happy to see CMS continue some of the flexibilities in the QPP proposed rule for 2018. Nick also shared our appreciation that CMS is allowing clinicians to report Merit-based Incentive Payment System (MIPS) data using several reporting methodologies for each category.

He is excited for virtual groups to begin in 2018 which will allow individual and small practices to join together to participate in MIPS.

Nick understood that the Government Relations Committee did not have time to conduct an in-depth analysis of the QPP proposed rule. Nick asked the Government Relations Committee to continue sharing ideas with him on the QPP once the more detailed analysis is complete. He recognizes that he lacks the on-the-ground perspective of most industry stakeholders such as HBMA. The Government Relations Committee is looking forward to continuing to serve as a resource to the House Ways and Means Committee.

The group was scheduled to meet with staff from the Senate Finance Committee after meeting with Nick, but that meeting had to be postponed. The Government Relations Committee meets with high-level staffers who control most of the policy making process. This allows the Committee to make the most effective use of our limited time on Capitol Hill. However, sometimes the schedules of these high-level staffers are at the mercy of the Senators they work for, which was the case for the Government Relations Committee's meeting with Senate Finance Staff.

The Senate's repeal/replace bill was introduced at the exact same time that our meeting with the Senate Finance Committee was scheduled. Kim Brandt, the staffer we were scheduled to meet with was one of the lead staffers on the Senate's ACA repeal/replace bill. Kim was unable to meet with the group because she was briefing the Republican Senators on the bill. She regretted missing our meeting as we have had many productive meetings in the past and offered to reschedule the meeting to a conference call.

Prior to the meeting, Kim informed the Government Relations Committee that she would be leaving the Finance Committee in July to become a Senior Policy Advisor to CMS Administrator Seema Verma. This truly speaks to the importance of the Government Relations Committee's relationship building efforts. HBMA spent the past several years cultivating a relationship with a staffer who now will be directly advising the leader of CMS. Many agency and congressional staff do not remain in the same position for very long and rarely do they move to a lesser role.

## STRATEGIC PARTNER MEETING – FOSTERING COLLABORATION

The Government Relations Committee continued its tradition of reserving time to meet with other organizations to discuss policies of mutual interest, as well as ways for our organizations to collaborate.

In addition to HBMA, the meeting was attended by Heather McComas and Laura Hoffman from the **American Medical Association (AMA)**, Rob Tenant from the **Medical Group Management Association (MGMA)**, the **Workgroup for Electronic Data Interchange (WEDI)**'s new President and CEO, Charles Stellar, and Bob Still, Executive Director of the **Radiology Business Management Association**. HBMA Government Relations Committee Member, Sherri Dumford also represented the **Healthcare Administrative Technology Association (HATA)** of which she is also a member.

One of the policies the group discussed was our mutual opposition to the Health Plan ID (HPID) regulations that have been indefinitely delayed by the Centers for Medicare and Medicaid Services (CMS). HBMA, along with several of the organizations at this meeting, testified before the National Committee on Vital and Health Statistics (NCVHS) calling for CMS to not move forward with implementation of its HPID rule. We all agree that the HPID policy as proposed would not provide any administrative help and would cause additional administrative burdens.

The Government Relations Committee shared our strategic goal of achieving better HIPAA Administrative Simplification enforcement and compliance. We asked the attendees about work they are doing on administrative simplification and if there is an opportunity to collaborate.

Prior authorization is a key initiative for several of the organizations. An MGMA internal survey shows that the vast majority of their members believe prior authorization is getting worse. According to the AMA, practices are spending an average of 16 hours a week per-physician on prior authorization. Further, plans approve almost every prior authorization request which begs the question of what purpose it actually serves. The group agreed that perhaps there is a place for prior authorization to remain as a fraud prevention tool if it is only required for bad actors.

Development of a claims attachment standard was discussed as well. We all agree that a claims attachment standard is long overdue. Both claims attachments and prior authorization are connected in that claims attachments are often needed to prove medical necessity for a prior authorization.

Implementing a claims attachment standard will make prior authorization for several procedures much more streamlined.

Additionally, the group agreed that many HIPAA standard transactions do not actually provide any useful information that results in actual administrative simplification.

The attendees also agreed that more needs to be done by CMS to enforce Administrative Simplification compliance. We discussed asking Congress to weigh in through a non-legislative option such as language in a bill report that accompanies legislation. The purpose of report language is to clarify Congressional intent. Report language does not carry the force of law but it would be a highly influential "shot across the bow" to pressure CMS into using its enforcement authority.

The attendees also discussed the possibility of a joint letter to Secretary of Health and Human Services (HHS) Tom Price on the need for better enforcement.

Of course, the CMS 2018 Quality Payment Program (QPP) proposed rule was a topic for discussion. All of the organizations at the meeting had similar reactions to the proposed rule.

Many of the changes, such as raising the low volume provider threshold, are welcome proposals.

Virtual credit cards were also discussed. All of the organizations do not like how payers use virtual credit cards (which carry a fee) over traditional checks or EFT payments. This is an issue that the groups have discussed in past joint meetings

and we will continue to collaborate to push for changes to the use of virtual credit cards such as making it an "opt in" program versus the current "opt out" format.

All of the organizations shared our concerns over the challenges of the CMS Social Security Number Removal Initiative (SSNRI), which replaces SSNs on Medicare beneficiary cards with a new, Medicare Beneficiary Identifier (MBI) number. SSNs are sometimes the only way to identify a patient. There is concern that the new MBI system will not be as effective. The groups agreed to consider opportunities to collaborate on education for members and advocacy on this issue.

Finally, the organizations discussed holding these meetings more regularly than the once-a-year HBMA Government Relations Committee visit. The organizations will meet quarterly or hold semi-annual conference calls to continue this collaboration. The invitation will be extended to several other organizations that wanted to attend but could not be at the meeting. This will help the organizations stay on top of our stated interest in collaborating on letters, advocacy and education.

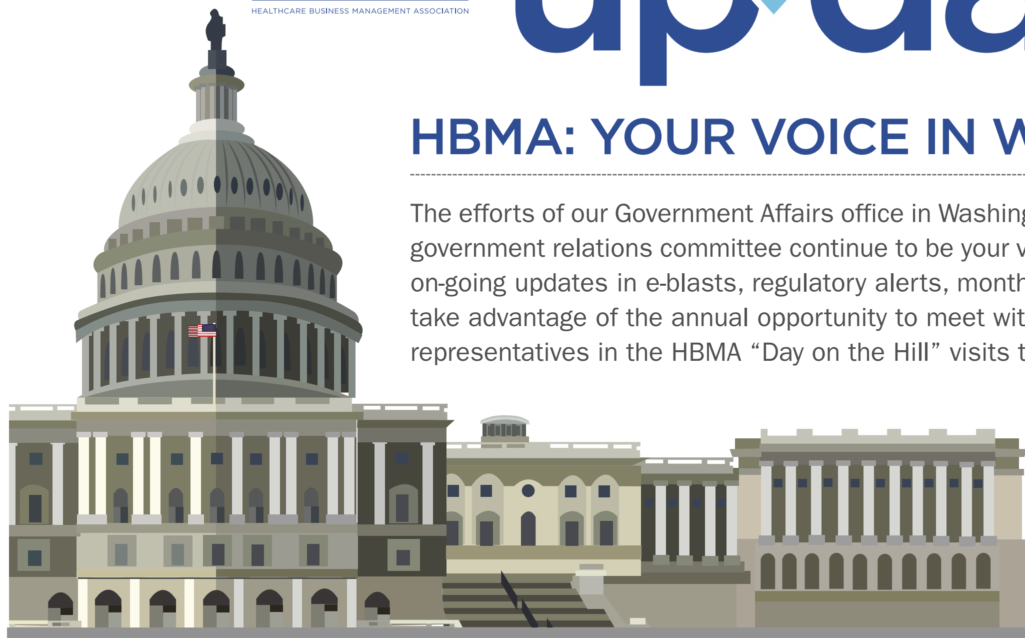
## CONCLUSION

The HBMA Government Relations Committee 2017 Federal Advocacy Trip was incredibly successful. The meetings are not just HBMA asking for changes to Medicare policy. The visits are an important opportunity to establish HBMA as a resource to policy makers. Having held these meetings every year for over a decade, HBMA has made great improvements in how we serve as a resource to policy makers.

Each year, these meetings result in new opportunities for collaboration that extend beyond the once-a-year meetings. The Government Relations Committee is proud of the progress made during these meetings and is excited for the opportunities to continue collaborating with policy makers and industry partners that lay ahead. ■

GOVERNMENT RELATIONS

update



HBMA: YOUR VOICE IN WASHINGTON

The efforts of our Government Affairs office in Washington, DC, and the work of the government relations committee continue to be your voice in Washington. Look for on-going updates in e-blasts, regulatory alerts, monthly Washington Updates, and take advantage of the annual opportunity to meet with the office of your personal representatives in the HBMA "Day on the Hill" visits to Capitol Hill.

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