AMGA
Advancing High Performance Health

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Speaker Paul Ryan
H-232 the Capitol
Washington, DC 20515

Dear Speaker Ryan,

On behalf of the AMGA, an organization representing 450 multispecialty medical groups and integrated delivery systems representing approximately 175,000 physicians caring for one-in-three Americans, we would like to express our appreciation for your efforts to improve the U.S. healthcare system.

As work begins in the 115th Congress, there will be many opportunities to address important health policy issues, and we look forward to being a resource for you as these critical policies are discussed and developed.

AMGA would like to share with you our thoughts on issues of importance to medical groups and health systems, including:

- Creating a pathway to value
- Implementing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- Ensuring appropriate healthcare coverage
- Preserving Medicare Advantage (MA)
- Refining Accountable Care Organizations (ACOs)
- Preserving access to advanced diagnostic imaging in the medical group setting
- Strengthening Graduate Medical Education (GME)

Creating a Pathway to Value

Policymakers in Congress and the Administration have made clear their intent to transform the way health care is financed and delivered in this country. Congressional passage of MACRA charts our system on a path to payment risk for providers over the next few years.

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Over the past two years, AMGA has conducted two risk readiness surveys of our membership to obtain a snapshot of the progress and challenges these leading multispecialty medical groups and integrated systems of care face during this transformation of the U.S. healthcare system. There remain significant obstacles in the healthcare market that must be addressed to ensure the transition from payment for volume of services to payment for value is successful.

Access to Claims Data

Providers have expressed concern with the lack of access to timely Medicare and commercial payer administrative claims data. In order to manage a patient population, providers need data to ensure the most effective course of action in improving health outcomes. **Congress should require federal and commercial payers to provide access to all administrative claims data to healthcare providers.** At the moment, access to this data is often denied or limited.

Standardization of Data

Even those providers with access to data face challenges. Endless amounts of time and resources are currently being spent on translating data sets from different types of payers. **Congress should require federal and commercial payers and providers to standardize data submission and reporting processes.** Currently, medical groups submit data to different insurance companies in different formats, creating a massive administrative burden and a diversion of resources from providing care to reporting data.

Access to Capital

Access to capital is a major impediment to taking downside risk, under which providers share in financial losses. In order to prepare for this transition, **Congress should allow providers to use income on a tax-free basis to invest in taking downside risk.** These monies would be tax-free if used to make the multi-million dollar investments in the infrastructure necessary to take downside risk or if used to offset losses in risk contracts. Lack of access to capital is a significant impediment to taking risk and use of these tax-free funds would also ease concerns over consolidation.

Implementing MACRA

We appreciate Congressional passage of MACRA, which repealed the sustainable growth rate payment mechanism and aims to bring more stability to Medicare physician reimbursement. The law grants providers predictable payments until 2019 when two new systems will be implemented: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). During this time of transition, AMGA members have been working to prepare for this new payment system to provide an even higher level of care.

MACRA also begins to transition from volume-based Medicare payments to payments based on value by mandating provider payment risk. The legislation relies significantly on the creation of Advanced APMs to incentivize this transition to a value-based payment model. Beginning in 2019, physicians and medical groups may qualify as an APM participant and receive a 5% bonus if they meet certain requirements. To qualify as an Advanced APM participant, providers must meet or exceed minimum revenue thresholds coming from Advanced APMs or minimum numbers of Medicare beneficiaries in APMs. In 2019, 25% of a provider's Medicare revenue must come from APMs. In 2021, 50% of revenue must come from an APM,

25% of which must be from Medicare. This threshold increases to 75% in 2023, 25% of which must be from Medicare revenue.

However, these requirements as currently drafted are unlikely to be met and will not attract the critical mass of physicians and medical groups necessary to define success. In order to ensure APMs are viable, we make the following recommendations:

Count Medicare Advantage (MA) Revenue in 2019

Many providers contract with MA plans, which incent coordinated care and value-based payment, a tenet of MACRA. But in 2019, MA revenue will not count towards providers' calculations to qualify as an Advanced APM. **Congress should allow MA revenue to count in payment year 2019 to ensure that providers have greater opportunities to participate in APMs, which have the potential to improve overall population health.**

Not Penalize Providers in Areas That Lack Commercial Risk Products

According to AMGA's 2nd annual risk readiness survey, 64% of AMGA members reported that they had little to no access to commercial risk products in their local markets. This is relevant because in 2021, providers' participation in commercial risk products will assist them in meeting revenue threshold requirements for the Advanced APM program. Congress should not penalize providers if there are insufficient levels of risk arrangements in their local markets. **If there is an insufficient level of commercial risk penetration in a local market, an Advanced APM should instead have to meet the 25% Medicare financial threshold to qualify for the Advanced APM incentive.**

Allow All ACOs to Qualify as Advanced APMs

Congress should allow all federal ACOs to qualify as Advanced APMs. Currently, only downside risk ACOs can qualify as Advanced APMs although all ACOs require multimillion-dollar investments in information technology, care process re-design, and staffing needed to develop the competencies necessary to participate in value-based payment.

It is important to note that of the 480 ACOs currently in the Medicare Shared Savings Program (MSSP); only 42 or 8% of ACOs were not in Track 1. These 42 ACOs take downside risk and would qualify as an Advanced APM. If policymakers want to ensure that these 438 remaining ACOs continue to participate in quality-driven care, participants in these care models must receive the Advance APM incentives under MACRA.

AMGA supports MACRA's goal of developing new APMs that better align quality with cost. However, current APM requirements are unlikely to be met, and we do not believe the program will attract sufficient numbers of medical groups and physicians to make the program successful. Adopting the changes noted above will allow Congress to meet its goal of transitioning Medicare Part B into a truly value-based payment system.

Ensuring Appropriate Healthcare Coverage

While healthcare coverage will continue to be an issue before Congress, we believe any Affordable Care Act (ACA) legislation should be concurrent to, or closely followed by, legislative action to ensure continuous affordable coverage. Without affordable coverage, those patients could lose access to health services, and may forego preventative care. Any ACA replacement plan deserves careful consideration by Congress and stakeholders.

Preserving MA

More than 30% of all Medicare beneficiaries have enrolled in MA plans and our members care for a large number of these patients. MA plans align incentives to provide better care at lower costs by allowing our members to invest in care coordination activities that keep patients healthy and out of the hospital. The payment structure utilized by MA incentivizes the team-based approach of multispecialty medical groups and the provision of the right care at the right time.

Despite this success, however, in recent years MA has remained under threat of additional cuts required by law or from regulatory changes issued by the U.S. Department of Health and Human Services. Disruptions to MA plans may also take the form of plans being forced out of the insurance marketplace altogether, which can limit beneficiary access. **Congress should carefully consider any MA policy change to ensure that it does not lead to decreased beneficiary access.**

Refining Accountable Care Organizations (ACO)

In the 114th Congress, Reps. Diane Black (R-TN) and Peter Welch (D-VT) introduced legislation to make important improvements to the federal ACO program, the ACO Improvement Act (H.R.6101). This bill encourages patient engagement by allowing all ACOs to waive copays and cost sharing for primary care services. The ACO Improvement Act reduces regulatory burdens by waiving, for all ACOs, site-of-service requirements for Medicare reimbursement of telehealth services. H.R. 6101 would also allow for prospective assignment of beneficiaries for all ACO tracks, so that providers know whom their patients are and could better coordinate their care.

The Centers for Medicare & Medicaid Services has made some improvements to the ACO Program, such as extending the participation in the MSSP Track 1 from a maximum of three years to a maximum of six years and proposing an improved benchmarking policy. However, legislative relief is still necessary to improve the program. Additional legislative changes should include creating more incentives for all ACOs, modifying the Minimum Savings Rate, developing an appropriate risk-adjustment methodology, and continuing fraud and abuse waivers for ACOs after they leave the program. **We strongly urge Congress to pass the Black/Welch bill and any other legislation to improve the ACO program in the 115th Congress.**

Preserving Access to Diagnostic Imaging in a Medical Group Setting

The in-office ancillary services (IOAS) exception within the Stark physician self-referral law permits multispecialty medical groups and integrated healthcare delivery systems to deliver high-quality, advanced diagnostic imaging services to Medicare beneficiaries. In the past, there have been proposals that would eliminate advanced diagnostic imaging services from the IOAS exception, effectively prohibiting efficient healthcare delivery systems from providing these services to their patients. Medical group patients would be

forced to receive these services outside of their usual healthcare system – losing the fundamental advantages to receiving care in a medical group such as:

- Use of a uniform medical record contained in an electronic medical record system;
- Care management protocols incorporating evidence-based medicine; and
- Receiving care from a team of providers that interact and collaborate with each other in formulating a plan that will best serve the patient.

AMGA member medical groups and systems devote considerable resources to determining the proper usage of advanced diagnostic imaging services, including utilizing decision-support tools to ensure that clinical decision-making is supported by evidence before ordering advanced diagnostic imaging for their patients.

Legislative proposals that would eliminate or narrow the scope of the IOAS exception would negatively impact the ability of high-quality providers to coordinate and manage the care of their patients. **We ask that the IOAS exception be preserved so that our members can continue to provide the very best care to their patients.**

Strengthening Graduate Medical Education (GME)

Strengthening GME is essential due to the increasing demand for healthcare services associated with the rapidly aging population, physician shortages, and the increase in the number of new patients with access to health insurance.

Physicians graduating as a M.D. or D.O. will spend three to seven years in a residency program and much of the funding for these programs comes from Medicare in the form of direct payments (to cover the cost of the educating residents) and indirect payments (to cover the cost of the treating complex patients at teaching hospitals). Because of the years necessary to train a physician, projected shortages need to be addressed now so that patients will have access to the care they need.

Multispecialty medical groups and integrated delivery systems employ a large number of physicians and require an adequate pool of residency-trained physicians to meet the growing demand for their services. Despite the growing demand due to the aging population, Congress has not increased the number of residency slots Medicare will fund since the implementation of the 1997 Balanced Budget Act. Unless the cap on federally funded residency slots is lifted, there will not be enough physicians to care for the growing elderly population as well as replace the currently aging physician workforce. **AMGA supports enhancing essential GME funding to maintain and build a physician workforce that can manage the ever-growing patient population.**

Thank you for considering our views and we look forward to working with you during the 115th Congress.

Sincerely,

Donald W. Fisher, PhD, CAE
President and CEO - AMGA