



One Prince Street  
Alexandria, VA 22314-3318  
☎ 703.838.0033  
✉ 703.548.1890

## 2019 Issue Brief Addressing America's Rising Health Care Costs

### Issue

The U.S. spends more on health care than any other nation in the world. According to a report from the Centers for Medicare & Medicaid Services' Office of the Actuary, the U.S. is projected to spend \$5.96 trillion on health care between 2018 and 2027, an estimated growth in spending of 5.5% per year. The most effective way to lower these overall costs is to continue moving the system toward a value-based approach, and away from the fee-for-service system. Aligning payments with goals to reduce cost and improve care coordination is the best way to ensure reduction in healthcare spending.

**AMGA recommends that Congress examine the following areas in health care to address the rising cost of health care:**

**Value:** AMGA members have shown that shifting toward value-based payment models, and away from fee-for-service, is key to reducing cost, while ensuring the best quality care for the patient. Thus, to ensure an easier transition to value and an ultimate reduction in costs, AMGA members identified the significant obstacles in the healthcare market impeding them from making the transition to value. There is currently a lack of access to timely Medicare and commercial payer administrative claims data. With this data, providers would be able to successfully manage their patient population. **Congress should require federal and commercial payers to provide access to all administrative claims data to healthcare providers.**

Additionally, even when providers have access to this data, they frequently spend an unnecessary amount of time and resources translating different data sets from different payers. **Policymakers should require federal and commercial payers and providers to standardize data submission and reporting processes.**

**Reduce Cost in Medicare:** Reducing cost in Medicare necessitates aligning financial incentives around care delivery and implementing value-based programs in a way that provides adequate incentives to move to value.

*Medicare Advantage:* The Medicare Advantage program has shown that by aligning incentives, systems can lower costs and provide better care. **Policymakers should ensure the viability of the program by avoiding cuts to MA rates, and by promoting MA plan design innovation and flexibility.**

*MACRA Implementation:* In implementing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Centers for Medicare & Medicaid Services (CMS) has significantly slowed the

evolution to a value-based system by limiting participation in value-based programs. CMS' exclusion of providers from participating in the Merit-based Incentive Payment System (MIPS) is an example of this. The MIPS program is the payment system within MACRA designed to transition providers to value-based payment arrangements, and does so by incentivizing providers through +/- payment adjustments based on their performance in the program. CMS has significantly weakened the MIPS program by excluding approximately 58% of providers in performance year 2019. Because MIPS is budget neutral, these exclusions result in insignificant payment incentives for high-performing providers. **Policymakers should no longer exclude providers from participating in MIPS, as doing so undermines congressional intent for the program and reduces the available payment adjustments.**

The second, more advanced payment pathway within MACRA, the Advanced Alternative Payment Model (APM), currently limits participation within the program. At present, to qualify as an Advanced APM, providers must meet or exceed minimum revenue thresholds from APMs, or meet a minimum number of Medicare beneficiaries in these models. In 2019, 25% of a provider's revenue must come from APMs. This threshold continues to increase every two years until it reaches 75% in 2023. These threshold requirements are unlikely to be met and will not attract the critical mass of physicians and medical groups needed to ensure success of the APM program. **Policymakers must allow for increased participation within the Advanced APM program by eliminating revenue and patient thresholds.**

**Decrease Administrative Burden and Provide Regulatory Relief:** Policymakers should reduce unnecessary regulatory requirements in the Medicare program, thus allowing providers to focus their time on improving care. The following are examples of regulations Congress should address.

*Quality Measurement:* AMGA members currently report hundreds of different quality measures to numerous public and private payers, the majority of which are not useful in evaluating or improving the quality of care provided. **Policymakers should work to harmonize and scale down the amount of existing quality measures for all providers in value-based arrangements.**

*Physician Self-Referral Reform:* As Medicare transitions to value-based arrangements, the need for "Stark Law," the federal legislation governing physician self-referral, has decreased. **Policymakers should modernize the Stark Law to account for integrated delivery systems that incentivize appropriate use of services.**

**Price Transparency:** Since most patients have no idea of the true price of their healthcare goods and services, higher prices do not correlate to higher quality. **To encourage competition in the market, policymakers should support increased price transparency.**

**Patient Engagement and Accountability:** In order to address the issue of rising healthcare costs, patients must also have an active role in their healthcare choices. **Patients should have access to their medical record, as well as prices for pharmaceuticals and services.**

**Foster Innovation:** AMGA members have consistently developed innovative models that have improved health outcomes while reducing healthcare costs. **Policymakers should incentivize innovation to move the healthcare system further along in value.**