American Medical Group Association

The Best Medicine *in* America.
The Best Medicine *for* America.

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

Dear Speaker Ryan,

On behalf of the American Medical Group Association (AMGA), we would like to express our appreciation for your efforts to improve the U.S. healthcare system. AMGA represents some of the country's largest integrated healthcare delivery systems and multi-specialty medical groups. More than 165,000 physicians practicing within AMGA member organizations provide healthcare services to 133 million patients, or over one in three Americans.

As Congress continues its work in the 114th 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 will continue to advocate on issues of importance to medical groups including:

- Implementing the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015
- Improving provider risk readiness
- 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)

MACRA Implementation

We appreciate Congressional passage of MACRA which repealed the sustainable growth rate payment mechanism and eliminated the annual end-of-year race to stop significant payment cuts to physician Medicare reimbursement. The law grants providers stable payments over four years which allows medical groups to plan, develop budgets, and create care processes that better meet the needs of their patients.

MACRA also begins to transition Medicare payments from volume to value by mandating provider payment risk. The legislation relies significantly on the creation of Alternative Payment Models (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 are eligible to receive a 5% bonus if they meet certain requirements. 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.

APM Revenue Thresholds

To qualify as an APM participant, providers must meet or exceed minimum revenue thresholds coming from 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 Medicare revenue.

While a value-based payment system is where the system needs to go, commercial payors are generally not offering risk based payment arrangements in local markets making it difficult for medical groups to meet these thresholds. In fact, according to AMGA's risk readiness survey, 22% of our members indicated that no insurers were offering risk-based products in their market, while 48% declared that only 1 to 19% of insurers were offering risk-based arrangements in their market. In the federal sector, uneven results in the ACO program and other value-based payment initiatives means satisfying the Medicare portion of APM revenue will be challenging as well. Consequently, these threshold requirements, while well intentioned, do not appear to reflect a realistic picture of APM revenues in the healthcare market and are unlikely to be satisfied.

Timeline

Beginning the APM program in 2019 will unnecessarily limit the number of medical groups and physicians that will participate in APMs. According to AMGA's risk readiness survey, 41% of AMGA member organizations need between three and five years before they can accept downside risk. In fact, 17% of our members stated they needed six or more years to be able to successfully accept downside risk. The majority of our members have made multi-million dollar investments in the infrastructure needed to take risk and they continue to need more time before they can succeed in a risk environment. Other physicians are likely to be far behind this curve. We believe that delaying this program until 2021 would ensure increased provider participation and consequently enhance the long-term viability of APMs.

Nominal Risk

Finally, APM participants will be required to take on more than "nominal" downside risk to be considered an APM. However, "nominal" is not defined in MACRA. At a minimum, we believe the definition should include the multi-million dollar investments our members will make in information technology, care process re-design, and staffing needed to develop the competencies necessary to take on more than "nominal" downside risk. Medical groups are at risk for these costs and they should be included in the definition of "nominal" downside risk.

MACRA states that ACOs are APMs. However, it is unclear if Track 1 ACOs, which do not accept downside risk, would be included as APMs. The Centers for Medicare and Medicaid Services (CMS) preliminarily estimated in 2011 that the average start-up and first-year operating expenses for establishing an ACO is $1.8 million. That figure is five years old and vastly underestimates actual costs. Track 1 ACOs are already at risk for these investments and should be considered APMs. We further note that of the 434 ACOs currently in the Medicare Shared Savings Program (MSSP) program, only 22 or 5% of ACOs are not in Track 1. If policymakers want to ensure that these 412 ACOs continue to participate in quality driven care, participants in these care models must receive the 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.

Provider Risk Readiness

As already noted, policymakers in Congress and the U.S. Department of Health and Human Services (HHS) have made it clear that they are embarking on an ambitious transformation of the way healthcare is financed. Recent HHS pronouncements on tying 90% of Medicare payments to value by 2018 and Congressional passage of MACRA essentially mandate that healthcare providers take on payment risk over the next few years.

While there has been much discussion in Washington on where the system needs to go (i.e., value/risk), there has been far less discussion on how to get there. AMGA's risk readiness survey shows there are significant obstacles in the healthcare marketplace that make any rapid transition to value-based payments difficult. Importantly, few payors have extensive experience sharing risk with providers and consequently few providers have experience managing risk. Data problems also serve as significant impediments to taking risk. Fortunately, there are tools Congress can authorize that will help providers be successful in a value-based payment system, whether in an APM, ACO, or a commercial risk arrangement.

The tools providers need include having timely access to all Medicare and commercial administrative claims data. Without this data, it is difficult for providers to manage patients or patient populations, especially those with multiple chronic conditions. Also, data sharing between Medicare, commercial payors, and the provider community must be standardized so needless time and money is not spent on collecting and making data actionable. An effective patient attribution policy is also critical. It is difficult for providers to be "accountable" for cost and quality when they do not know who is under their care. Adequately adjusting for risk and revising quality measures that actually measure healthcare outcomes are important issues as well.

Congress has a significant opportunity to transition the healthcare system from one that pays for volume to one that rewards value. However, this transition is a dramatic departure from the current state of healthcare financing and if Congress overlooks the tools providers need for success in a new payment system, the opportunity for true reform may be lost.

Preserve Medicare Advantage

Over 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 multi-specialty medical groups and the provision of the right care, at the right time.

Despite this success however, MA remains under threat of additional cuts required by law or from regulatory changes issued by HHS. Cuts to MA should be eliminated because they lead to decreased services and programs for patients while increasing costs. Disruptions to MA plans, as a result of continued cuts, may also take the form of plans being forced out of the insurance marketplace altogether, which can limit beneficiary access.

Accountable Care Organizations Refinements

The participants in the MSSP and the Pioneer ACO demonstration have all made significant improvements in care processes and the delivery of high-quality care, while reducing utilization of healthcare services. Although most of these ACOs have increased quality and achieved the goal of saving money for Medicare, program results have been uneven at best. ACOs have also encountered significant obstacles in program design that threaten not only their own success, but also the future viability of federal ACOs.

AMGA member medical groups have invested significant financial, clinical, operational, and leadership resources to establish sophisticated care management infrastructures and organizational cultures necessary to support the goals of the program. They have done so because it is the right thing to do for their patients and they want to assist Congress, CMS, and other payors to create the new payment models that reward coordinated, patient-centered care with measurable improvements in outcomes.

However, ACOs need a workable financing and operational structure that adequately incentivizes this important work. Those changes include creating incentives for all ACOs, modifications to the Minimum Savings Rate (MSR), a workable attribution methodology, an appropriate risk adjustment policy, and continuation of fraud and abuse waivers beyond the term of an ACO. As policymakers continue to work to transform the way healthcare is delivered and financed, ensuring that ACOs have all the necessary tools to operate effectively and efficiently should be a priority.

Diagnostic Imaging in a Medical Group Setting

The in-office ancillary services (IOAS) exception within the Stark physician self-referral law permits multi-specialty medical groups and integrated healthcare delivery systems to deliver high-quality, advanced diagnostic imaging services to their patients. 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. They would also lose the advantages inherent in receiving their 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 devote significant 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.

Narrowing the scope of the IOAS exception would negatively impact the ability of high-quality providers to coordinate and manage the care of their patients. At a time when the federal government is providing incentives for healthcare providers to integrate healthcare delivery, such as in Medicare ACOs, narrowing or eliminating the IOAS exception runs counter to Congressional intent to stimulate greater integration and care coordination in the healthcare delivery system. We ask that the IOAS exception be preserved so that our members can continue to provide the very best care to their patients.

Strengthen Graduate Medical Education (GME)

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

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).

Multi-specialty 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 these caps are increased, 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 in this remaining year of the 114th Congress.

Sincerely,

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