AMGA
Advancing High Performance Health

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Speaker Nancy Pelosi
U.S. House of Representatives
H-232 the Capitol
Washington, DC 20515

Dear Speaker Pelosi;

On behalf of AMGA, I appreciate the opportunity to outline our priorities as you begin the 2nd session of the 116th Congress. Founded in 1950, AMGA represents more than 450 multispecialty medical groups and integrated delivery systems, representing approximately 175,000 physicians, who care for one in three Americans. Our member medical groups work diligently to provide innovative, high-quality, patient-centered medical care. With your work on Capitol Hill already underway, there will be many opportunities to address critical health policy issues, and we look forward to serving as a resource for you as they are discussed and developed.

AMGA would like to share our thoughts on the most important issues for medical groups and health systems, including:

- **Creating a Pathway to Value**
  Access to Claims Data
  Data Standardization
  Quality Measurement
- **Promoting Access to Care for the Chronically Ill**
- **Implementing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)**
  Allow for more Advanced Alternative Payment Models (APMs) participation
  Eliminate exclusions in the Merit-based Incentive Payment System (MIPS)
- **Preserving Medicare Advantage (MA)**
- **Improving Accountable Care Organizations (ACOs)**
- **Reforming Physician Self-Referral (Stark Law)**
  Preserving access to advanced diagnostic imaging in the medical group setting
- **Increasing Access to Telehealth Services**
- **Addressing Rising Healthcare Costs**

Creating a Pathway to Value

Both Congress and the administration have made clear the necessity to transform the way health care is financed and delivered in this country. The passage of MACRA started our system on a path to value-based care.

In 2015, Congress passed MACRA with the intention of fundamentally remodeling how physicians are reimbursed. To better monitor the transition, AMGA began surveying its members to determine the challenges they face in the shift to value-based payment arrangements. In response to four annual risk-readiness surveys, AMGA members consistently cited access to administrative claims data as one of the most significant impediments to taking risk for their patient populations. AMGA fully supports the shift to value-based care, because not only does it improve patient care coordination, but it also reduces overall cost. For the transition to value-based care to be successful, however, AMGA members need the proper tools.

Access to Data

Access to claims data not only helps providers deliver better care, but it additionally empowers the patient. Patient access to claims data will lead to better conversations with their providers and subsequently lead to better health outcomes. Access to data also ensures more accountability between the provider and the payer regarding a patient's care. Both the payer and the provider have an obligation to ensure the best health outcomes for the patient, and timely data-sharing is integral to achieving this goal.

AMGA has worked with the Senate Health, Education, Labor and Pensions (HELP) Committee to include a commercial claims data-sharing provision within its *Lower Health Care Costs Act.* The provision, *Section 501,* requires a group health plan or health insurance issuer offering group or individual health insurance coverage to make commercial claims data available to both patients and providers through application programming interfaces. The broader bill passed out of the HELP committee and now awaits further consideration in Congress. Congress should ensure that this provision is included in an upcoming healthcare legislative package.

Data Standardization

Providers with access to data still face challenges, as they must spend excessive amounts of time and resources translating data sets from different types of payers. Currently, medical groups are required to submit data to different insurance companies in different formats, creating a massive administrative burden and resulting in a diversion of resources from providing care to reporting data. Congress should require federal and commercial payers and providers to standardize data submission and reporting processes.

Quality Measurement

Both the Medicare Payment Advisory Commission and the results of AMGA's risk-readiness surveys indicate that federal and commercial payers require far too many quality measures, many of which have little to do with improving healthcare outcomes. Additionally, research shows that current quality measurement benchmarking and performance measurement are financially burdensome. Payers should move to a more outcomes measurement-based system supported by claims data.

AMGA developed a set of measures (attached at the end of this letter) that are evidence-

based and improve care and the patient experience. By using a value-based, standardized measurement set can result in improvements in quality of care, decreased reporting costs, and improved patient satisfaction, as providers will be able to focus on care delivery, rather than data reporting. Moreover, offering a standard set of measures for contracts with payers can reduce the variation in the measures that are reported and help eliminate unnecessary administrative burden. Policymakers should work to harmonize and scale down the amount of existing quality measures for all providers in value-based arrangements.

Promoting Access to Care for the Chronically Ill

Chronic care management (CCM) is a critical part of coordinated care. In 2015, Medicare began reimbursing providers for CCM under a separate, billable code in the Medicare Physician Fee Schedule.

This code is designed to reimburse providers for non-face-to-face care management. Under current policy, Medicare beneficiaries are subject to a 20% coinsurance requirement to receive these services. Consequently, only 684,000 out of 35 million eligible Medicare beneficiaries with two or more chronic conditions benefitted from CCM services over the first two years of the payment policy.

Removing the coinsurance payment requirement would facilitate more comprehensive management of chronic care conditions and improve the health of patients. Providers and care managers have discovered several positive outcomes for CCM beneficiaries, including improved patient satisfaction and adherence to recommended therapies, improved clinician efficiency, and decreased hospitalizations.

AMGA applauds Congressional action on H.R. 3436, the Chronic Care Management Improvement Act, which was introduced in the House of Representatives in June 2019. The legislation would waive Medicare's CCM code coinsurance requirement. This bill was approved in the House Ways & Means Committee, and AMGA further urges Congress to pass the bill into law.

Implementing MACRA

AMGA appreciates congressional passage of MACRA, which repealed the Sustainable Growth Rate payment mechanism with the goal of bringing stability to Medicare physician reimbursement. The law created two new systems: The Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). AMGA members have dedicated significant time and resources to deliver care to provide an even higher level of care under these new payment systems. However, we have concerns and recommendations regarding the implementation of these two systems.

Allow for More APM Participation
Some APM requirements must be revised to ensure the model remains a viable option for providers. To qualify for the program, providers must meet or exceed minimum revenue thresholds from APMs or minimum numbers of Medicare beneficiaries in these models. For example, in 2021, 50% of revenue must come from APMs—up from 25% in 2019. This threshold increases to 75% in 2023. However, these APM requirements are unlikely to be met and will not attract the critical mass of physicians and medical groups necessary to ensure success of the program. Among the challenges are a lack of access to commercial risk products and limited Medicare Advanced APM options. Congress must eliminate these arbitrary revenue thresholds so that more providers can make the transition to value-based care as intended.

Congress needs to offer meaningful incentives so providers will make the multimillion-dollar investments necessary to build a value-based platform. By extending the annual 5% APM lump sum bonus payment

beyond the program's 2024 sunset date, Congress would strongly demonstrate to the healthcare community its commitment to offering a stable and predictable risk platform to providers ready to move to value.

Eliminate MIPS Exclusions
The other system, MIPS, was designed as a transition tool to value-based payment in the Medicare program, where providers would be rewarded for their investments in health information technology, care management processes, and people. However, the Centers for Medicare & Medicaid Services (CMS) has not implemented MIPS as Congress intended.

By creating a system where high performers are rewarded and poor performers who received a lower payment rate are incented to improve, MACRA was designed to transition Medicare to a value-based payment system. Under the MIPS program, providers can earn an annual adjustment to their Medicare Part B payments based on their performance. This started in 2019 with a positive or negative adjustment range of 4% that eventually increases to 9% in 2023. However, CMS has excluded approximately 50% of providers from participating in MIPS. Because MIPS is budget neutral, these exclusions result in insignificant payment adjustments to high-performing providers. For example, in 2020, CMS expects a 1.5% payment adjustment for high performers, compared to a potential 5% adjustment provided for in the law. In 2021, CMS expects a 2% payment adjustment for high performers, although the statute authorizes up to a 7% adjustment.

These insignificant payment adjustments do not acknowledge the considerable investments our members have made in transitioning to a payment mechanism that is based on the quality and cost of care provided. Eliminating the MIPS exclusions from the program would both improve the distribution of MIPS payment adjustments and provide meaningful incentives for all providers to move to value-based care.

Preserving Medicare Advantage (MA)

More than 33% of all Medicare beneficiaries have enrolled in MA plans, and AMGA members care for many of these patients. MA plans incentivize preventative care and value, resulting in improved care at a reduced cost. The payment structure utilized by MA incentivizes the team-based, multispecialty medical group approach to providing the right care at the right time. Congress should ensure that any MA policy changes do not lead to decreased beneficiary access.

Improving ACOs

Currently, CMS includes all beneficiaries in the regional adjustment factor used to calculate an ACO's benchmark, which disadvantages ACOs that perform well relative to the rest of their region and makes it more difficult for them to earn shared savings. We applaud Congressional introduction of H.R. 5212/S.2648, which would remedy this issue by removing an ACO's population from CMS' regional adjustment calculation. It will help ensure that an ACO is not penalized for making improvements in its market and is not competing against itself if it performs well relative to that market. AMGA believes this change will encourage more ACOs to participate in the Medicare Shared Savings Program (MSSP) and reward them for delivering higher quality, lower cost care, regardless of their geographic location.

AMGA members have consistently supported the MSSP, which seeks to move our delivery system to one that rewards value and outcomes. Congress should eliminate this flaw in the ACO benchmarking calculation to help ensure the successful transition to value-based care.

Reforming Physician Self-Referral (Stark Law)

Federal legislation and regulations governing physician self-referral, collectively termed the "Stark Law," were intended to prevent financial conflicts of interest around physician self-referrals in fee-for-service (FFS) settings. As Medicare transitions to value-based arrangements, the need for these protections and related self-referral and anti-kickback regulations lessens since incentives to overutilize healthcare services diminish. Currently, participants in the MSSP or ACO program often must receive several fraud-and-abuse waivers because the programs' financial incentives drive providers to improve the continuity, coordination, and continuum of care for assigned ACO beneficiaries. The Stark Law's prohibitions, which were drafted more than 30 years ago, impede the physician-hospital relationships necessary to address overuse of services.

The Stark Law was drafted to address volume of service increases in FFS Medicare. It has virtually no application in value-based models, which incentivize the appropriate use of services. Congress should update the law to account for changes in care models that have led to more integrated care delivery.

Preserving Access to Advanced Diagnostic Imaging in the Medical Group Setting
The in-office ancillary services (IOAS) exception within the Stark physician self-referral law permits multispecialty medical groups and integrated systems of care 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, integrated 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 support from a team of providers who interact and collaborate with each other in formulating a plan that will best serve the patient.

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 Congress preserve the IOAS exception so that AMGA members can continue to provide the very best care to their patients.

Increasing Access to Telehealth Services

Telehealth and remote-monitoring services offer Medicare beneficiaries substantial access and care improvement opportunities, including self-management support, better outcomes, and increased patient satisfaction. Additionally, telehealth leads to greater spending efficiency for the Medicare program. To increase patient access to telehealth services, policymakers should follow through on the expansion of telehealth payment in the MA patient population and waive the geographic limitations for telehealth use for all providers participating in value-based models.

Certain state licensure and credentialing policies restrict how and where providers can deliver care. AMGA members provide care in a collaborative manner and need standardized federal licensing and credentialing to ensure that the best provider can provide or suggest the most appropriate therapy to a patient, regardless of the state in which a provider or patient resides. Policymakers should establish a national standardized licensing and credentialing system so patients can have access to the highest quality care that also delivers the best value.

Addressing Rising Healthcare Costs

The U.S. spends more on health care than any other developed nations in the world, and the U.S. Chamber of Commerce found that 76% of voters want Congress to prioritize lowering healthcare costs for all Americans. Multispecialty medical groups and integrated systems of care are the most effective models to provide the highest quality medical services to Americans, while at the same time controlling costs and promoting efficiency. Such groups and systems are more likely to invest in health information technology, practice team-based care, collect and analyze data, and provide direct physician feedback on clinical care. Further, evidence shows there is greater collaboration among physician specialties and allied health professionals in large, multispecialty medical groups and other integrated systems, which is key to successful care coordination and cost reduction.

We need to align payments with the goals of the healthcare system, and the best way to do this is to reduce the barriers to success in value-based care arrangements. If it were simpler for practices to participate and succeed in risk-based models, more would adopt those that incentivize outcomes—better care quality, improved patient experience, and lower costs—rather than the volume of services provided. Congress should encourage widespread participation in value-based arrangements.

Thank you for considering our views and we look forward to working with you throughout the year.

Sincerely,

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer
AMGA

AMGA Measure Set

	Measure
1	Emergency Department use per 1000
2	SNF admissions per 1000
3	30-day all cause hospital readmission
4	Admissions for acute ambulatory sensitive conditions composite
5	HbA1C poor control >9%
6	Depression screening
7	Diabetes eye exam
8	Hypertension (HTN)/high blood pressure control
9	CAHPS/health status/functional status
10	Breast cancer screening
11	Colorectal cancer screening
12	Cervical cancer screening
13	Pneumonia vaccination rate
14	Pediatric well child visits (0-15 months)