



Advancing High Performance Health

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March 1, 2019

Chairman Lamar Alexander  
United States Senate  
Committee on Health, Education, Labor, and Pensions  
Washington, DC 20510

Dear Chairman Alexander:

On behalf of AMGA and our members, I appreciate the opportunity to respond to your questions regarding how to lower healthcare costs in the United States. Founded in 1950, AMGA represents more than 450 multispecialty medical groups and integrated delivery systems, representing approximately 177,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide innovative, high-quality, affordable, patient-centered medical care, and they will be a tremendous resource as we work to identify the best ways to solve the problem of rising healthcare costs. We have identified the following steps that Congress can take to address the growing price of health care in our nation.

#### **Create a Pathway to Value**

The United States spends more on health care than any other nation 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. A study from the Health Care Cost Institute found that in 2017, healthcare spending per person increased 4.2%, while overall utilization only increased by 0.2%, meaning Americans are paying more for the same amount of health care. This is mainly due to an increase in prices –17.1% from 2013 to 2017.

According to a new 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, a 19.4% share of gross domestic product. It is estimated that spending will grow at an average rate of 5.5% per year during the same period, driven primarily by demographic and economic changes, as Americans grow closer to the Medicare age of eligibility.

A shift toward a value-based approach and away from the fee-for-service system is the most effective way to lower overall costs. 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, more would adopt the models that incentivize outcomes – better care quality, improved patient experience, and lower costs – rather than volume of services provided.

AMGA is dedicated to preparing our members to assume risk in value-based payment models where they are accountable for total cost of care, knowing that this is key to reducing costs while providing the highest level of care. To bolster their success, AMGA conducted four annual risk-readiness surveys of our membership to gauge their progress and identify the challenges they face in the transition to value. Our survey results identified several significant obstacles in the healthcare market impeding that transition.

#### *Access to Claims Data*

AMGA members have consistently rated a lack of access to administrative claims data as the most significant barrier to assuming risk. AMGA members report that while some payers share this data with them, the majority of payers do not. Without this data, it is challenging to manage the cost and quality of a population of patients, which is a goal of moving to value-based care. In order to accelerate the transition to value, Congress should require federal and commercial payers to provide accurate, timely access to all administrative claims data to healthcare providers in value-based arrangements.

#### *Standardization of Data*

Even when providers have access to data, they frequently spend an unnecessary amount of time and resources translating data sets from different types of payers. Different contracts require medical groups to submit varying types of data in various formats, creating a massive administrative burden and a diversion of resources from providing care to reporting data. According to an AMGA Consulting survey, for every 100 physicians AMGA member groups employ, they hire 17 IT professionals to support them. Congress should require federal and commercial payers and providers to standardize data submission and reporting processes.

#### *Commercial Payer Involvement in Risk*

In our most recent risk-readiness survey, 59% of respondents said they have little to no access to commercial risk products in their local markets. While the percentage represents an increase in payer involvement since our first survey in 2015, it also demonstrates that commercial payers are still largely not engaged in the risk market. Although many of the reasons for this lack of engagement are beyond the control of the health plan, to truly move the healthcare system to value, we need more engagement in the commercial environment. Payers and providers need to develop risk-based arrangements that result in decreased costs and service utilization, improved care, and a more fully aligned financing model for care delivery. Congress should work with provider and payers to fast track the move to value in the commercial setting.

#### **Reduce Costs in Medicare**

To reduce costs, we need to align financial incentives around care delivery and implement value-based programs in a way that provides adequate incentives to move to value.

#### *Medicare Advantage*

The Medicare Advantage (MA) system provides an excellent framework to align incentives. MA

has shown us that by aligning incentives, a successful system can lower costs and provide better care. Additionally, the program fosters cooperation among providers and plans to achieve success. Policymakers should ensure regulations reflect congressional intent as enacted in the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act by safeguarding newly expanded telehealth and supplemental benefits.

#### *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 through policies that limit participation in value-based programs.

Regulations to implement MACRA which exclude providers from the Merit-based Incentive Payment System (MIPS) requirements is a prime example of these policies. MIPS was designed as the on-ramp to value-based payment in the Medicare program, where providers would be rewarded for investments in health information technology (HIT), care management processes, and clinical practice redesign. These investments in infrastructure are required to reduce total cost of care for a population.

CMS is concerned that solo practitioners and small practices will be unable to succeed if the system moves too quickly to value, and has excluded many from participation. However, by excluding 58% of providers from MIPS requirements in performance year 2019, CMS has failed to implement MIPS as Congress intended. Because MIPS is budget neutral, these exclusions result in insignificant payment adjustments to high-performing providers. For example, it is estimated that high performers will receive an aggregate payment adjustment in 2019 of 1.1%, compared to a potential 4% allowed in the statute. 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, where the statute suggests a potential 7% adjustment.

MIPS no longer rewards providers for superior performance and provides no return on the investments made to improve patient care while saving the system money. Instead of a way to transition to value, MIPS has become an expensive regulatory compliance exercise with little to no impact on quality or cost. Policymakers should no longer exclude providers from participating in MIPS.

We also must allow for more participation in Advanced Alternative Payment Models (APMs), the other pathway to value under MACRA. APM requirements must be revised to ensure the model remains a practical option.

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 2019, 25% of a provider's Medicare revenue must come from APMs. In 2021, 50% of revenue must come from APMs, and the threshold increases to 75% in 2023. These APM requirements are unlikely to be met and will not attract the critical mass of physicians and medical groups needed to ensure success due to a lack of commercial risk products and limited Medicare Advanced APM options.

Congress should eliminate these arbitrary thresholds so that more providers can make the

transition to value as envisioned under MACRA. Additionally, the annual 5% APM lump sum bonus payment should be extended to attract more providers to participate in APMs.

### **Decrease Administrative Burden and Provide Regulatory Relief**

Other factors that are contributing to the growing cost of health care are burdensome administrative expenses and redundant Medicare regulations. AMGA supports policies that reduce the Medicare programs' unnecessary regulatory requirements so providers can focus their time and talents on providing the best possible care, rather than diverting their resources toward regulatory compliance activities that add to the overall cost of care without improving patient outcomes.

The best way to address the issue of regulatory burden, while simultaneously incentivizing Medicare's transition away from fee-for-service, is to focus regulatory reform efforts on improving current value-based models for participants. Specific examples that Congress should address include the following:

#### *Quality Measurement*

Both federal and commercial payers require far too many quality measures, which have little to do with improving healthcare outcomes. Our members 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. Research shows that the way quality and performance is measured currently is also financially burdensome. A study from Weill Cornell Medical College indicates that, on average, U.S. physician practices across four common specialties annually spend more than \$15.4 billion and 785 hours per physician to report quality measures – a significant amount of time and money. Payers should reduce the number of quality and performance measures for all value-based providers and move to a more outcomes-based system supported by claims data.

The current quality measurement and reporting system suffers from duplicative measures and a lack of data standardization. To address this issue, AMGA has endorsed a set of 14 value measures designed to simplify the reporting process and limit the burden on providers and group practices. Use of these core measures will ultimately save providers time and reduce costs while improving overall quality of care. By offering a standard set of measures for value-based contracts with payers, the AMGA measure set can reduce the variation in the measures reported and help eliminate unnecessary confusion and administrative burden.

The AMGA value measure set is a tool to help reduce the reporting burden on providers and improve outcomes reporting and benchmarking. 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*

Federal legislation and regulations governing physician self-referral, collectively termed the "Stark Law," were drafted more than 30 years ago to prevent financial conflicts of interest around physician self-referrals in fee-for-service settings. As Medicare transitions to value-based

arrangements, the need for these protections and related regulations decreases, as incentives to over-utilize healthcare services diminish. The Stark Law has almost no application in value-based models that incentivize appropriate use of services, and it should be modernized to account for our more integrated delivery system.

### **Promote Price Transparency**

According to a 2018 *JAMA* study, “The United States spent approximately twice as much as other high-income countries on medical care, yet utilization rates in the United States were largely similar to those in other nations. Prices of labor and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference in overall cost between the United States and other high-income countries.” The cost of health care will continue to rise unless we advance price transparency for consumers. Most patients have no idea of the true price of their healthcare goods and services, and higher prices do not correlate to higher quality. For the healthcare system to have the cost-saving benefits of a true market, price transparency is necessary to encourage competition in the market.

### **Encourage Patient Engagement and Accountability**

We cannot solve the issue of rising healthcare costs without addressing the need for patient engagement and accountability. However, we need to incentivize and empower patients to help move the system towards value. Patients must be able to access and understand their healthcare information in order to make informed choices. This includes the information in their medical record, as well as the prices for pharmaceuticals and services. Incentives could entice patients to live healthier lives, and in turn save the system money by reducing trips to the doctor and hospital admissions and the need for expensive medications due to preventable chronic conditions.

Patients must have an active role in their healthcare choices. Changing a patient’s behavior may be difficult, but people must be encouraged and incentivized to take responsibility for their healthcare decisions. The results will benefit them by keeping them healthy and out of the hospital, as well as offering them a better quality of life. With the right tools and information, patients can make better decisions that will benefit them as well as reduce healthcare costs.

### **Foster Innovation**

Innovation is key to lowering healthcare costs in the United States. Multispecialty medical groups and integrated delivery systems have consistently produced the most innovative solutions for improving health outcomes while reducing healthcare costs. For years, AMGA members have demonstrated the most effective and efficient models for providing the highest quality of medical services to Americans, while at the same time saving money through innovations in care coordination, data collection and analysis, and care models that move our system towards value-based care. Congress and the administration can help continue this success by incentivizing innovation as we move to value.

We thank you and the committee for consideration of our comments, and would be honored to serve as a resource as you continue to explore ways to lower healthcare costs. Should you have questions or need more information, please do not hesitate to contact AMGA's Chief Policy

Officer Chester A. Speed, J.D., LL.M., at 703.838.0033 ext. 364 or [cspeed@amga.org](mailto:cspeed@amga.org).

Sincerely,

A handwritten signature in black ink that reads "Jerry Penso". The signature is fluid and cursive, with "Jerry" on top and "Penso" below it.

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