



January 9, 2015

Speaker John Boehner
H-232 The Capitol
Washington, DC 20515

Dear Speaker Boehner:

On behalf of the American Medical Group Association (AMGA), we would like to welcome you to the 114th Congress. AMGA represents some of the country's largest integrated healthcare delivery systems and multi-specialty medical groups. More than 160,000 physicians practicing within AMGA member organizations provide healthcare services to 120 million patients (approximately one in three Americans). As Congress convenes, there will be numerous opportunities to improve our healthcare system and we look forward to being a resource for you as policies are developed. We want to take this opportunity to update you on our policy priorities and highlight the high-quality healthcare that our members provide to your constituents. In this new Congress, AMGA will continue to advocate on issues pertinent to medical groups including:

- Refining Accountable Care Organizations (ACOs)
- Preserving Medicare Advantage (MA)
- Addressing Medicare physician payment reform by repealing the Sustainable Growth Rate (SGR) formula
- Healthcare data transparency
- Preserving access to diagnostic imaging in a medical group setting

Improve ACOs

The participants in the Medicare Shared Savings Program (MSSP), and the Pioneer Accountable Care Organization Program (Pioneer, collectively, ACOs) 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 the future viability of these programs.

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, the Centers for Medicare and Medicaid Services (CMS), and other payers 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 should include a longer transition period to risk-sharing, 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. Congress continues to have an unprecedented opportunity to transform the way healthcare is delivered and financed, and we would like to continue to work with you ensure the success of the ACO program.

Preserve MA

Approximately thirty percent of Medicare beneficiaries are enrolled in a MA plan. MA plans incentivize high-quality care that AMGA member groups provide by supporting the management of chronic conditions that result in healthier beneficiaries. These incentives also help medical groups reduce avoidable hospitalizations and emergency department visits.

However, the MA program is under threat of additional cuts required by law or from CMS regulatory changes. Congress should eliminate cuts to MA because these reductions lead to decreased beneficiary access, decreased care coordination, and decreased management of chronically ill patient populations. Repeated cuts to MA will hamper the work that has been done to move the delivery system away from a fee-for-service model and toward one that emphasizes and incentivizes integration, value, and care coordination.

SGR reform

The development and implementation of a Medicare physician payment system that provides long-term stability in physician payments is essential to the long-term sustainability of the Medicare program. The last Congress passed a short-term SGR patch that delayed the scheduled 24 percent physician payment cut, originally scheduled to take effect on April 1, 2014, for one year, through March 31, 2015. We hope that Congress can work together with stakeholders and agree on a long-term solution to revise the Medicare system.

As you know, the last Congress developed a bi-partisan SGR repeal bill that would have replaced the current system with one that rewards value over volume of services provided. However, several key issues must still be addressed in that legislation in order to ensure that any replacement system provides a strong foundation for a new physician payment model. These operational improvements are described more fully below.

Alternative Payment Models (APMs)

The SGR repeal bill relies on alternative payment models (APMs), which includes ACOs, to incentivize provider transition to value-based care. Qualifying APMs are eligible to receive an additional 5 percent of the payment amount for their professional covered services in the preceding year. This is a significant incentive. However, unless practical financing and operational models for potential APMs are developed, we are concerned that a foundation for a new Part B payment mechanism will be largely unutilized.

Under the legislation, to be considered a “qualifying APM participant”, the APM must take downside risk. While it is generally accepted that providers will eventually accept some level of risk, doing so requires significant clinical re-design, as well as operational, financial, information technology, and cultural changes. When combined with the significant APM revenue threshold requirements, we believe most medical groups, indeed most physicians, will simply opt-out of participating in APMs.

Additionally, the establishment of effective attribution methods must be an integral aspect of successful APMs. Medical groups report that up to 40 percent of patients attributed to them in the MSSP, Pioneer ACO programs, or other value based payment systems, receive some, most, or all of their care outside of the system. Physicians are willing to be held accountable under new payment models, but to effectively redesign care processes for patient populations requires a clear understanding of who their patients are.

New methods of attribution could include requiring Medicare patients to prospectively choose a primary care physician (PCP), an ACO, or an APM, that is responsible for their care for a specified period of time.

We believe APMs can serve as the transitional payment mechanism between fee-for-service and capitation. However for APMs to be successful in this role, we recommend Congress eliminate the risk taking requirement currently in the legislation as well as provide effective attribution strategies. These changes would help ensure significant participation by medical groups in APMs and satisfy the goal of the legislation to transition Medicare Part B from a volume-based payment model to one that rewards value.

Medical Group Experts Establishing Quality Measures

We ask Congress to consider the development of a measurement system that is suited to address integrated delivery systems and multi-specialty medical groups, with such systems closely involved in the development of the quality measures. Medical groups utilize a team-based approach and have devoted significant resources to developing a team culture within their system. Requiring high-performing health systems to report separately on every physician specialty measure, as required by the SGR repeal bill, creates quality silos that work against the team-based culture in High-Performing Health Systems.

Increased Data Sharing

A payment system that rewards value over volume would also require robust data sharing between healthcare providers and health plans, whether federal or private, and is particularly important for larger group practices and healthcare systems. The development of a long-term SGR repeal policy over the years has highlighted the need for timely data sharing on performance in quality and resource use. Requiring Medicare to share this information, in a standardized and easy to utilize format, is an essential step toward accountability for patient care and helps create a true partnership between payers and healthcare providers.

Creation of an APM for High-Performing Health Systems

AMGA believes that a high-performing health system is distinguished by certain attributes that contribute to the delivery of high-quality, patient-centered, efficient care. AMGA has developed a definition for a high-performing health system and believes that medical groups that meet this definition should qualify as participating in an APM and be eligible for the increased payments as described in the SGR repeal legislation.

As Congress seeks to find a viable alternative to the SGR, we continue to advocate on the need for comprehensive SGR reform which rewards value over volume.

Data Transparency efforts

Healthcare data, and its transparent use, has the potential to better educate the consumer/patient and drive significant change and improvement in the delivery system. In our current healthcare system, data is fragmented, inadequate and siloed. While medical groups with Electronic Medical Records (EMRs) are able to review their own clinical data, claims data, which covers office visits, tests, procedures, lab results, medications, etc., is critical to painting a fuller picture of the patient. Claims data is needed for providers to understand the care that happens outside of the medical group office and to better predict risk and identify chronically ill and high cost patients. In other words, medical groups, indeed all providers, need both clinical and claims data to manage a patients' care and their costs. However, access to claims data is uneven. Some commercial payors will share its claims data with providers while many will not. To improve care and decrease costs, AMGA recommends the development of a central data warehouse, coordinated by a trusted party that would house administrative claims data from a variety of sources (e.g.,

Federal healthcare programs, commercial payors, labs, pharmacy benefit managers, etc.). Providers would be able to access this data and paint an accurate picture of their patients' needs.

Additionally, we recommend that Congress require CMS to convene a stakeholder group to discuss the creation of a standardized process for the collection of data, submission and reporting of data, as well as feedback reporting. By allowing providers to access all forms of data and by standardizing the data submission process, Congress has the opportunity to dramatically improve the quality measurement system for patients and providers.

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 other organized systems of care 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, and they would 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 to 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 the Medicare Shared Savings and Pioneer ACO programs, 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 during this Congress, the IOAS exception be preserved so that we can continue to provide the very best care we can to our patients.

Thank you for considering our views and we look forward to working with you in this new Congress.

Sincerely,



Donald W. Fisher, Ph.D, CAE
President and CEO - AMGA