



Advancing High Performance Health

February 4, 2019
Speaker Nancy Pelosi
U.S. House of Representatives
H-232 the Capitol
Washington, DC 20515

Dear Speaker Pelosi;

On behalf of AMGA and our members, we appreciate the opportunity to outline our priorities as you begin your legislative session. 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. As work begins in the 116th 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 being 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
 - Implementing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
 - Promoting data utilization
- Preserving Medicare Advantage (MA)
- Promoting access to care for the chronically ill
- Improving regulations in value-based models
- Refining Accountable Care Organizations (ACOs)
- Preserving access to advanced diagnostic imaging in the medical group setting
- Incentivizing behavioral health integration efforts
- Gaining access to substance use disorder data for population health efforts
- Strengthening Graduate Medical Education (GME)

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Creating a Pathway to Value

Policymakers in Congress and the administration have made clear their intent to transform the way health care is financed and delivered in this country. Congressional passage of MACRA charts our system on a path to value for providers over the next few years.

Implementing MACRA

We appreciate congressional passage of MACRA, which repealed the Sustainable Growth Rate payment mechanism, and aims to bring more stability to Medicare physician reimbursement. The law grants providers predictable payments until this year, when two new systems will be fully implemented: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). AMGA members have dedicated significant amounts of time and resources to deliver care under these new payment systems to provide an even higher level of care. However, we have concerns and recommendations regarding the implementation of these two systems.

Eliminate MIPS exclusions

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

Under the MIPS program, providers have the opportunity to earn an annual adjustment to their Medicare Part B payments based on their performance starting in 2019, with a positive or negative adjustment range of 4%. That range eventually increases to 9% in 2023. By creating a system where high performers were rewarded, and poor performers who received a lower payment rate were incented to improve, MACRA was designed to transition Medicare to a value-based payment system. Despite the MACRA statute, CMS has excluded approximately 60% of providers from MIPS requirements in the past few MACRA regulations. Because MIPS is budget neutral, these exclusions result in insignificant payment adjustments to high-performing providers. For example, high performers are estimated to receive an aggregate payment adjustment in 2019 of 1.1%, compared to a potential 4% allowed under 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 for high performers, but the statute suggests a potential 7% adjustment.

These insignificant payment updates fail to reward providers for superior performance in the MIPS program and provides nominal return on investments. Unfortunately, MIPS has devolved into an expensive regulatory compliance exercise with little to no impact on quality or cost. Policymakers should no longer exclude providers from MIPS.

Allow for more APM participation

Advanced APMs are the other pathway to value under MACRA. While well intentioned, APM requirements need to be revised to ensure the model remains a viable 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. 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. This is due to a dearth of commercial risk products and limited Medicare Advance APM options. Congress must eliminate these arbitrary thresholds so that more providers can make the transition to value as envisioned under MACRA.

Promoting data utilization

Over the past four years, AMGA conducted four risk-readiness surveys of our membership to obtain a snapshot of their progress and the challenges providers face in the transition to value. To ensure the successful transition from volume to value, legislators must address significant obstacles in the healthcare market identified in our survey results, including those related to data.

Access to claims data

Providers have repeatedly expressed concern with the lack of access to timely Medicare and commercial payer administrative claims data. In order to manage a patient population, providers need data to ensure the most effective course of action in improving health outcomes. At the moment, access to this data is often denied or limited. Congress should require federal and commercial payers to provide access to all administrative claims data to healthcare providers in value-based arrangements.

Standardization of data

Even those providers with access to data face challenges, as they must spend excessive amounts of time and resources translating data sets from different types of payers. Currently, medical groups submit data to different insurance companies in different formats, creating a massive administrative burden and 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.

Preserving Medicare Advantage (MA)

More than 33% of all Medicare beneficiaries have enrolled in MA plans, and our members care for a large number of these patients. MA plans are a financing model, which focuses on preventative care and value. This aligns with the medical group delivery model, resulting in improved care at a reduced cost. The payment structure utilized by MA incentivizes the team-based, multispecialty medical group approach and as a result, providing the right care at the right time. Congress should carefully consider any MA policy changes to ensure that they do not lead to decreased beneficiary access.

Promoting Access to Care for the Chronically Ill

We applaud Congress' passage of the CHRONIC Care Act in early 2018. This law includes various policies to improve the lives and care of the chronically ill patient population. In addition, AMGA supports the Chronic Care Management (CCM) code that was initiated in 2014. This code is designed to reimburse providers for non-face-to-face care management.

We remain concerned that use of the CCM code requires beneficiaries pay a 20% copayment for the service. AMGA medical groups have repeatedly stated that they have found it difficult to collect this copayment amount because these services were often times provided by AMGA members for free previously. AMGA members consider CCM to be a preventative service, which should not have a copay requirement. Congress should mandate that CMS waive the current CCM code copay for beneficiaries to ensure appropriate use of the code as well as maximum access for patients.

Improving Regulations in Value-Based Models

Medicare regulations have increased in number and scope and are a significant contributor to provider burnout. Importantly, many federal regulations actually impede the physician-patient relationship. AMGA supports policies that generally reduce the Medicare programs' regulatory reach so our member providers are best able to expend their energies and talents toward providing the best possible patient care, rather than diverting their attention toward regulatory compliance activities that do not improve the patient experience. AMGA believes the best way to address the issue of regulatory burden, while simultaneously incenting Medicare's transition away from fee-for-service, is to link the regulatory reform efforts described below to providers participating in value-based payment models. We contend that Congress should address the regulatory issues detailed below.

Quality measurement

Both the Medicare Payment Advisory Commission (MedPAC) and AMGA's risk-readiness survey indicate that federal and commercial payers require far too many quality measures, which have little to do with improving healthcare outcomes. Research shows that current quality measurement benchmarking and performance measurement also are financially burdensome. Payers should reduce the number of quality measures for all value-based providers and move to a more outcomes-based system supported by claims data.

In fact, AMGA developed a value-based set of measures that are evidence-based and improve care as well as the patient experience. We believe that by using a standardized measurement set, there can be 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, by offering a standard set of measures for contracts with payers, this set 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.

Meaningful Use Stage 3

AMGA remains concerned with Health Information Technology (HIT) Stage 3 Meaningful Use (MU). Electronic health record (EHR) use in payment systems that are based on value make increased HIT utilization mandatory. We remain unconvinced that the substantial investment in time required to complete Stage 3 MU documentation actually improves patient care and patient outcomes. Additionally, HIT vendors have been slow in updating their products to meet Stage 3

requirements. Since the benefits of requiring Stage 3 MU is both uncertain and since Stage 3 product selection limited, we believe that policymakers should suspend this HIT requirement.

Preferred provider list

Under current Medicare regulations, patients who are discharged from an acute care facility and are in need of post-acute care (PAC) follow-up treatment are simply provided information on PAC facilities in their area. Under the Next Generation ACO demonstration, providers are allowed to present patients with a list of preferred PACs that meet certain quality criteria, including a minimum star rating. This policy helps ensure Medicare beneficiaries receive care in a higher-quality care setting. Providing a beneficiary with a preferred provider list simply offers them more information and improved care transparency. All providers within the Medicare program should be afforded this ability to inform patients of PAC providers so the program needs to be reformed.

Physician self-referral Stark Law reform

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 lessen, as incentives to over-utilize healthcare services diminish. Participants in the Medicare Shared Savings Program or ACO program often have to receive several fraud and abuse waivers since the financial incentives push providers to improve the continuity, coordination, and continuum of care for assigned ACO beneficiaries. Indeed, 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 models, which incent appropriate use of services. Therefore, this law needs to be updated to account for changes in care models that have led to more integrated care delivery.

Telehealth

Telehealth and remote-monitoring services offer Medicare beneficiaries substantial access and care improvement opportunities, including self-management support, comparatively better outcomes, and higher patient satisfaction. Telehealth also 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.

3-day qualifying inpatient stay for skilled nursing facility care

The Social Security Act requires Medicare beneficiaries to have an inpatient hospital stay of no fewer than three consecutive days to be eligible for Medicare coverage of skilled nursing facility (SNF) care. This rule dates back to the inception of the Medicare program, and is referred to simply as the SNF 3-Day Rule. The three-day stay is not required for other forms of post-acute care, including home health care or inpatient rehabilitation facility stays. Today, under pay-for-value arrangements, the 3-Day Rule has become, as MedPAC previously noted, “antiquated.” The rule actually hinders timely and appropriate care, impedes care coordination, heightens the risk of

iatrogenic harm from extended hospital stays, and is a burden on beneficiaries and their family caregivers. Policymakers should work to waive the qualifying inpatient stay requirement and implement policies that encourage providers to work with their patients to provide services in the most clinically appropriate location.

Refining Accountable Care Organizations

Participants in the federal Accountable Care Organization (ACO) program have made significant improvements in care processes and the delivery of high-quality care, while reducing healthcare utilization. ACOs have encountered significant obstacles in program design, which threaten not only their own success, but also the future viability of this program. AMGA members 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 ACO program. At a minimum, the ACO program needs the following policy changes to ensure viability of this population health initiative:

- Encourage patient engagement by allowing all ACOs to waive copays and cost-sharing for primary care services.
- Reduce regulatory burden by waiving site-of-service requirements for Medicare reimbursement of telehealth services for all ACOs.
- Synchronize rules across all federal ACO tracks. This will allow each risk track to operate under the same regulatory framework and ensure continuity when ACOs move up the risk continuum.
- Adjust ACO regional benchmarking used to determine if ACOs met expectations related to spending so they are not competing against themselves.

Preserving Access to Diagnostic Imaging in a Medical Group Setting

The in-office ancillary services (IOAS) exception within the Stark physician self-referral law permits multispecialty medical groups and integrated healthcare delivery systems 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 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
- Receiving care from a team of providers who interact and collaborate with each other in formulating a plan that will best serve the patient

AMGA member medical groups and systems devote considerable 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. 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 our members can continue to provide the very best care to their patients.

Incentivizing Behavioral Health Integration Efforts

Behavioral health integration (BHI) is an effort to improve coordination between primary care providers and behavioral health specialists in treating simultaneously the patient's physical and behavioral health needs. Several AMGA member medical groups have established collaborative care models within their organizations to provide effective treatment to patients with common behavioral health conditions, which may otherwise go untreated. As a result, they have improved health outcomes and reduced costs. Our member medical groups report that their patients who have chronic health conditions such as diabetes, chronic obstructive pulmonary disease, and chronic pain, often experience depression or anxiety. Therefore, being treated for these conditions as part of their care plan can improve treatment outcomes, reduce future office visits, and reduce hospital admissions. Collaborative care is also an effective and efficient strategy for addressing workforce shortages of mental health professionals. AMGA encourages Congress to support proposals that encourage collaborative care through appropriate Medicare reimbursement.

Gaining Access to Substance Use Disorder Data for Population Health Efforts

AMGA and our members remain engaged in population health efforts, which rely upon constant communication among multiple providers. One impediment to this collaboration is 42 CFR Part 2, which requires limiting the use and disclosure of patients' substance use records from certain substance use programs. Under current law, a patient must provide written authorization permitting each individual provider access to their substance use disorder records. A lack of access to the full scope of medical information for each patient can result in the inability of providers and organizations to deliver safe, high-quality treatment and care coordination. The Health Insurance Portability and Accountability Act (HIPAA) grants providers access to a wide range of patient data to manage population health, while still maintaining patient privacy protections. AMGA requests that Congress align the 42 CFR Part 2 law with HIPAA to alter access to patients' substance use information. This policy proposal would grant providers access to this data to manage population health, while still maintaining patient privacy protections.

Strengthening Graduate Medical Education

Strengthening GME is essential due to the increasing demand for healthcare services associated with the rapidly aging population, physician shortages, and the increased number of new patients with access to health insurance.

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. Because of the necessary time it takes to train a physician, projected shortages need to be addressed now, so that patients will have access to the care they need in the long term.

Multispecialty medical groups and integrated delivery systems employ a large number of physicians and require an adequate pool of residency-trained physicians to meet the increasing

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 the cap on federally funded residency slots is lifted, 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. Congress should lift the cap on federally funded residency slots.

Thank you for considering our views and we look forward to working with you during the 116th Congress.

Sincerely,

A handwritten signature in cursive script that reads "Jerry Penso". The signature is written in dark ink and is positioned above the typed name and title.

Jerry Penso, M.D., M.B.A.
President and CEO
AMGA