Power Points

AMGA's legislative and regulatory advocacy priorities

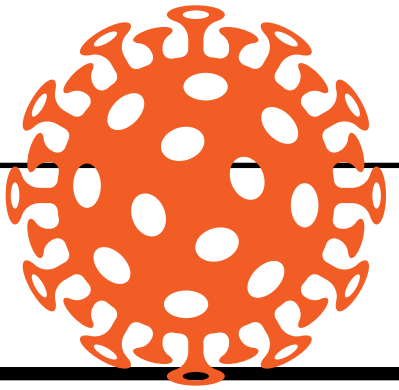
By AMGA Public Policy Team

AMGA's public policy team continues to advocate on behalf of the group practice model and integrated systems of care. As part of that effort, AMGA has developed several legislative and regulatory priorities for 2020, which ensure our membership has the patient information, regulatory framework, reimbursement support, and access to key decision makers to deliver care. The legislative and regulatory situation is constantly evolving and AMGA works to ensure federal officials understand not only how AMGA members coordinate care, but also the resources and tools needed to do so. For example, AMGA quickly contacted key federal officials within the Department of Health and Human Services (HHS) in response to the COVID-19 pandemic so that our members have the flexibility and tools to respond to this public health crisis.

Legislative Update

COVID-19

Even before President Trump signed emergency legislation in response to the coronavirus outbreak into law, AMGA contacted senior HHS officials with recommendations on how to implement newly authorized Medicare telehealth authority. The law includes a provision to allow Medicare patients to access telemedicine services for coronavirus treatment. AMGA immediately encouraged HHS to exercise its new authority and to waive the otherwise applicable telehealth requirements in the Medicare program so that providers can care for patients via telehealth, including from their homes. AMGA also wrote to the Centers for Medicare & Medicaid Services (CMS) with recommendations to ensure telehealth is available to all Medicare patients,



regardless of their location or COVID-19 status. Days after AMGA contacted federal regulators on this issue, HHS on March 18 issued a series of waivers that expanded the telehealth benefit so that, as of March 6, 2020, Medicare will pay for telehealth visits without the typical restrictions on site-of-service or geographic restrictions. For the duration of the public health emergency, patients can receive care from their homes.

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Access to Claims Data

Currently, one of AMGA's top priorities is working with Congress to ensure provider access to commercial payer administrative claims data. These efforts include AMGA's initial comment letter to the Senate Health, Education, Labor, and Pensions (HELP) Committee, which led to the inclusion of Section 501 in the Lower Health Care Costs Act, which allows providers access to administrative claims data through an application programming interface (API). The legislation passed out of the Senate HELP Committee in June 2019. AMGA pursued intense lobbying efforts to include access to claims data in a surprise billing package with key committees of jurisdiction, including the House Energy and Commerce Committee, the House Education and Labor Committee, and the House Ways and Means Committee. At press time, negotiations with these committees were still ongoing.

Chronic Care Management

AMGA has been instrumental in crafting legislation to eliminate the coinsurance payment for Medicare beneficiaries receiving chronic care management (CCM). In 2015, Medicare began reimbursing providers for CCM under a separate 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 the service. Consequently, only 684,000 patients out of 35 million Medicare beneficiaries with two or more chronic conditions benefited from CCM services over the first two years of the payment policy. Removing the coinsurance payment would facilitate more comprehensive management of chronic care conditions and improve the health of AMGA members' patients.

In June 2019, H.R. 3436[1], the Chronic Care Management Improvement Act, was introduced and quickly approved by the House Ways and Means Committee. The legislation would waive Medicare's CCM code coinsurance requirement. Rep. Suzan DelBene (D-WA) drafted this legislation at AMGA's request in the House, and several Senators have expressed interested in championing this issue as well.

Accountable Care Organizations

Participants in the federal ACO program have made significant improvements in care processes and the delivery of high-quality care, while reducing healthcare utilization. Although many ACOs have increased overall quality and saved Medicare dollars, program results have been uneven at best. AMGA continues to be a leader on ACO reform before policymakers in Congress and the administration.

Currently, CMS includes all beneficiaries in the regional adjustment factor that is 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.

AMGA helped craft H.R. 5212[2], the Accountable Care in Rural America Act, which would remedy this issue by removing an ACO's population from CMS' regional adjustment calculation. This will help ensure that the 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. The Senate companion measure, the Rural ACO Improvement Act (S.2648[3]), was introduced with AMGA's endorsement. AMGA members have consistently supported the MSSP, which seeks to move our delivery system to one that rewards value and outcomes. Additionally, AMGA is involved in the drafting of more comprehensive legislation that would strengthen the overall MSSP program.

Regulatory Update

Evaluation and Management

In its update to the Physician Fee Schedule for 2020, CMS responded to AMGA's concerns about restructuring payments for evaluation and management (E/M) services. Rather than pay a single blended payment rate for E/M visit levels 2 through 5, CMS revised its proposal and will continue to pay a separate rate for each E/M level. However, providers remain concerned about the overall impact to the Fee Schedule in 2021, as CMS has only provided illustrative examples of the policy change, rather than a detailed estimate. CMS needs to maintain budget neutrality if any changes to the work relative value units (RVUs) result in either an increase or decrease in the overall Fee Schedule.

CMS' policy is an effort to increase support for primary care so those specialties with significant revenue from E/M services will see an increase in reimbursement. Conversely, those specialties that do not frequently bill E/M codes will likely see a decrease in payment. Therefore, after stakeholders largely united in opposition to the blended payment rates in E/M codes, the landscape has shifted so that stakeholders are focused on more their specific payment interests, even though there has been widespread agreement about the need to increase support for primary care.

CMS has not provided a detailed estimate for what these changes will look like, because the policy takes effect in 2021. The agency did provide an illustrative example which showed increases in specialties such as endocrinology, and decreases in others, such as radiation oncology. There are only so many options for CMS if it wants to mitigate any large changes in payments that result from the budget neutrality requirements. CMS will be under considerable political pressure to minimize any possible cuts that result from the E/M changes. The most likely option for CMS is to change the conversion factor or the RVUs, so that any payment changes are not as large as they otherwise would be.

Empowering Beneficiaries Though Transparency

CMS is focused on ensuring beneficiaries have access to their healthcare information and data. From a proposal for the industry to adopt standardized APIs to support patient access to their data, to price transparency requirements, this administration has proposed several policies that are intended to help beneficiaries be more informed healthcare consumers.

For example, CMS issued a final rule in November 2019 that mandated that hospitals publicize payer-specific negotiated rates for 300 "shoppable services." The rule also required that the hospitals post their standard charges online in a machine-readable file. Of note is that CMS did not propose to include non-employed physician services as part of its transparency effort. This is because the agency has not determined how best to do so, rather than a lack of desire. CMS also proposed a separate rule that would require health plans to publish machine-readable files with their payment amounts for all healthcare services and items. The proposed rule also would require insurers to offer a tool to help consumers estimate their out-of-pocket costs for any item or service before they get care. CMS is using regulations to impose transparency requirements that are a part of an overall effort to ensure that patients have as much information as possible.

Additionally, in the contract year 2021 and 2022 Medicare Advantage (MA) and Part D proposed rule, CMS proposes several enhancements to the Part D program. Specifically, CMS proposed requiring that Part D plan sponsors implement a beneficiary real-time benefit tool (RTBT). This provision would go into effect on January 1, 2022, if finalized. The goal of the RTBT is to provide beneficiaries with accurate, timely, and clinically appropriate patient-specific real-time formulary and benefit information. Beneficiaries would be able to see cost information, formulary alternatives, and utilization management requirements. Plans could use an existing secure patient portal to meet the requirements, but can also develop a new portal or use a computer application. This information must also be available to beneficiaries if they call into the plan's customer service center. The rule proposes to allow plans to offer rewards and incentives to encourage beneficiaries to log on to the RTBT or call customer service to access this information.

Medicare Advantage Changes

MA continues to be an attractive option for both beneficiaries and AMGA members, as the program offers an expanded range of benefits for enrollees, as well as a financing mechanism and set of rules that provides a consistent regulatory framework for providers. For 2021, CMS is codifying several changes based on the 21st Century Cures Act. One of the major changes will allow patients with end-stage renal disease (ESRD) to enroll in an MA plan. CMS also is codifying the existing methodologies and standards it uses when determining network adequacy for MA plans. This will provide MA organizations with a greater understanding of how CMS measures and assesses network adequacy. Additionally, CMS is proposing to allow MA plans to receive a 10% credit towards the percentage of beneficiaries residing within certain time and distance standards, when they contract with certain telehealth providers—specifically dermatology, psychiatry, cardiology, otolaryngology, and neurology. Lastly, in order to expand access to MA plans where developing networks can be difficult, CMS is proposing to reduce the required percentage of beneficiaries in non-urban counties that must reside within the maximum time and distance standards from 90% to 85%.

By selecting MA, enrollees enjoy access to supplemental benefits and protection from high out-of-pocket costs. However, CMS needs to ensure that payments to plans adequately reflect the expense of treating high-need populations. For example, CMS sets ESRD payment rates on a statewide basis, rather than at the county level. This methodology fails to take into account statewide variation in costs. If plan payments for this population are inadequate, plans may not be able to provide the supplemental coverage that would help improve the lives of chronically ill patients.

AMGA Advocacy

AMGA advocates for priority issues affecting medical groups; promotes policymakers' and lawmakers' awareness of the advantages of practicing in a multispecialty medical group; represents members' interests in related associations and coalitions; and informs and advises members regarding implementation of, and compliance with, enacted and proposed legislation and regulations.

In addition, we promote policymakers' and lawmakers' awareness of medical groups' recognized excellence in delivering high-quality, cost-effective medical services to patients through coordinated care.

Through our efforts, members are assured that their interests are represented before many audiences, including Congress and federal agencies, in addition to other healthcare organizations and interest groups.

Find out more at **amga.org**.

Getting Involved

AMGA members need to get involved in the advocacy process by meeting and communicating with legislators both at home and in Washington, DC. AMGA provides several opportunities to get involved throughout the year.

Capitol Hill Day

For over a decade, AMGA's Capitol Hill Day provides medical group leaders with the opportunity to meet with their elected officials in Washington, DC, to ensure they understand the principles that guide our industry and to advocate for the issues that are most important to their medical group or health system. Meeting with your Members of Congress and their staff in person is the best way to influence change. AMGA's policy staff briefs all participants on relevant issues in advance and assists in scheduling meetings with the appropriate parties.

Participation is open to individuals at AMGA member medical groups and health systems and is complimentary (attendees cover travel and hotel expenses).

***To learn more about Capitol Hill Day, contact Christina Lavoie, J.D., director, government relations, at* clavoie@amga.org.**

Grassroots Network

AMGA members can also get involved by joining the recently launched Grassroots Network. The program connects you with your Senators and Representatives in Washington, DC, to form a meaningful dialogue on the issues affecting you and your patients. As a network member, you will receive best practice "how to" documents, template letters to send to your Members of Congress, legislative updates, alerts and intel on key issues, and access to a listserv to facilitate discussion among other members.

***To join AMGA's Grassroots Network, contact Sarah Skirmont, government relations coordinator, at* sskirmont@amga.org.**

District Advocacy Program

The most recent addition to AMGA's advocacy initiatives is the District Advocacy Program. The purpose of the program is to connect AMGA members with legislators in their district in order to ensure that AMGA's voice is heard at the regional level. District office meetings are a valuable tool that allow AMGA members to create long-term relationships with Members of Congress at the community level. District office meetings generally give advocates more face-to-face time with legislators, so that they can deliver their message on priority healthcare issues and reinforce AMGA's activities in Washington, DC. At present, the program is slowly being rolled out, and several AMGA members have already met with their members in the district regarding key AMGA priorities. GPJ

***For more information regarding this program, please contact Lauren Lattany, director, government relations, at* llattany@amga.org.**

References

1. H.R.3436 – Chronic Care Management Improvement Act. congress.gov/bill/116th-congress/house-bill/3436?q=%7B%22search%22%3A%5B%22H.R.+3436%22%5D%7D&s=1&r=1.
2. H.R. 5212 - Accountable Care in Rural America Act. congress.gov/bill/116th-congress/house-bill/5212?q=%7B%22search%22%3A%5B%22H.R.+5212%22%5D%7D&s=2&r=1.
3. S.2648 – Rural ACO Improvement Act. congress.gov/bill/116th-congress/senate-bill/2648?q=%7B%22search%22%3A%5B%22S.2648%22%5D%7D&s=1&r=1.