AMGA™

AMGA MACRA and Value-Based Care Task Force Recommendations

AMGA's six pillars to improve care delivery and continue the transition to high-value care

As the U.S. healthcare system stands at a pivotal juncture, the imperative to reassess and refine the future of healthcare financing to support modern care delivery and practices has never been more pressing. Central to this evolution are group practices and integrated systems of care, which are uniquely positioned to lead the transformation toward a more coordinated, efficient, and patient-centered model. These organizations have demonstrated the capacity to deliver high-quality care while managing costs, making them essential players in the journey toward value-based care (high-value care).

Founded in 1950, AMGA is a trade association leading the transformation of healthcare in America. Representing multispecialty medical groups and integrated systems of care, AMGA is the national voice promoting awareness of its members' recognized excellence in the delivery of coordinated, high-quality, high-value care. There are more than 177,000 physicians practicing in AMGA member organizations, delivering care to more than one in three Americans. AMGA is uniquely positioned to offer policy recommendations on programmatic improvements to Medicare.

Recognizing the approaching 10-year anniversary of the Medicare Access and CHIP Reauthorization Act (MACRA), AMGA established the **MACRA and Value-Based Care Task Force** in 2023 to build on the successes of the law, while also recognizing the potential for improvements. This initiative responds to congressional inquiries about ensuring that Medicare appropriately reimburses professional services under Part B and enhances the viability and sustainability of high-value care. The Task Force comprises members from some of the nation's leading multispecialty group practices and integrated care systems, all committed to transforming healthcare delivery in the United States.

The Task Force began its work by identifying policies and regulations within the Medicare reimbursement system that hinder the ability of AMGA members to provide optimal care. While MACRA aimed to shift Medicare from a fee-for-service model to one that rewards value, its execution has revealed challenges. These include complexities in the Merit-Based Incentive Payment System (MIPS), limited participation in Advanced Alternative Payment

Recommendations

Models (APMs), and the need for more robust support for small, rural, and underserved practices. Informed by their experiences delivering care under MACRA's reimbursement and regulatory framework, the Task Force examined all aspects of the care delivery reimbursement model.

Through comprehensive analysis, the Task Force identified six foundational pillars essential for reforming MACRA and advancing high-value care:

1. **Enhance Patient Engagement**: Empower patients to take an active role in their healthcare decisions.
2. **Improve Health Outcomes**: Address disparities to ensure all populations receive high-quality care.
3. **Protect Patient Dignity at End of Life**: Promote compassionate care that respects patient preferences.
4. **Remove Regulatory and Statutory Barriers**: Reduce administrative burdens that impede care delivery.
5. **Support Practices Serving Rural and Underserved Populations**: Ensure equitable resources and support for all providers.
6. **Ensure the Long-Term Sustainability of High-Value Care**: Establish a payment model that ensures long-term viability for providers.

This report presents the Task Force's policy recommendations for each pillar, aiming to guide policymakers in reauthorizing MACRA and shaping a simple and sustainable healthcare system that supports the ability of AMGA members to deliver high-value care. By removing regulatory and statutory barriers and enabling patients to engage with their provider teams on their treatment plans and goals, the Task Force's recommendations are designed to meet the needs of all patients across the country, regardless of location and income, by reforming Medicare's reimbursement system. By focusing on the strengths of group practices and integrated care systems, we can pave the way for a future in which high-quality, patient-centered care is accessible to all.

Enhance Patient Engagement in High-Value Care

AMGA Goal

Incentivize and empower patients to make informed decisions about their healthcare by designing care delivery and financing systems that eliminate access barriers and promote preventive care.

AMGA members recognize that meaningful patient engagement is critical to improving health outcomes, enhancing patient satisfaction, and increasing overall healthcare efficiency. Effective patient engagement strategies are essential to encouraging patients to take an active role in their health, adhere to treatment plans, and adopt healthier lifestyles.

To achieve this goal, AMGA recommends that Congress:

- **Offer financial incentives to Medicare patients for healthy behaviors**: Provide modest financial incentives, such as premium reductions or rewards, for participating in preventive health activities such as exercise programs or dietary improvements. These incentives can drive sustained behavior change, improve clinical outcomes, and reduce the long-term burden of chronic disease.
- **Waive Medicare cost-sharing requirements for chronic care and chronic care management services**: Eliminate out-of-pocket costs for Medicare beneficiaries with chronic conditions. Removing financial barriers would increase engagement in care and improve disease management. This would especially benefit low-income seniors, reducing disparities in access and care outcomes.
- **Permanently remove geographic and originating site restrictions for telehealth**: Permanently codify the Medicare waiver of geographic and originating site limitations to ensure broad, equitable access to telehealth services—especially in rural and underserved communities. Continued virtual access promotes care continuity and supports patients with mobility or transportation challenges.

Dr. Scott Hines on the Importance of Patient Engagement

Patient engagement is essential, not just for empowering individuals to take charge of their health, but also for building stronger relationships between patients and providers. When patients are informed and actively involved in their care, outcomes improve, providers can deliver more personalized treatment, and the entire healthcare system becomes more efficient and sustainable.

It helps reduce unnecessary hospital visits, improves adherence to treatment plans, and ultimately leads to better use of healthcare resources.

Engaged patients are partners in care—and that collaboration drives real, lasting health improvements. Financial incentives and eliminating obstacles to care, including cost, can further enhance patient engagement by making healthcare more accessible and motivating individuals to participate actively in their own care.

— **Scott Hines, MD**, *Chief Quality Officer, Crystal Run Healthcare*

- **Fund digital health navigators to bridge the digital divide**: Reimburse medical groups and health systems for employing digital health navigators who assist patients with technology. These navigators can help patients use telehealth platforms, understand health data, and engage with remote monitoring tools. Funding for navigators would ensure technology is an enabler, not a barrier.
- **Mandate data sharing from commercial payers to providers**: Require commercial insurers to provide timely access to claims data. Improved data sharing enables providers to better coordinate care, close care gaps, and manage population health. This would align payers and providers around shared value-based goals.

Offer financial incentives to Medicare patients for healthy behaviors

Affordability remains one of the most significant barriers to healthcare access in the United States. High copayments, out-of-pocket costs, and the absence of financial incentives deter patients from seeking care or following through on treatment plans, ultimately leading to poorer health outcomes and higher systemwide costs. Aligning financial incentives to support prevention and chronic disease management is essential to improving outcomes and reducing avoidable high-cost utilization.

Payment and care delivery structures can either support or deter patient engagement. Cost-sharing requirements and the fear of unexpected bills disproportionately affect patients with chronic or complex conditions. According to a study published in the *Journal of Internal Medicine*, 37.7% of participants cited concerns about cost as a reason for avoiding care.[1] To overcome these barriers, policymakers must implement payment and care delivery reforms that align with patient-centered care and promote sustained engagement, the hallmarks of high-value care.

Currently, financial incentives for patient engagement in traditional Medicare are limited and largely indirect, except in the Medicare Shared Savings Program (MSSP). These MSSP incentives generally offer direct financial rewards capped at $20 for primary care services.[2] By contrast, Medicare Advantage (MA) plans and private insurers commonly offer tangible rewards to patients, including gift cards, reduced premiums, or waived copays for participating in wellness-focused activities, such as physical exams, vaccination programs, or even gym memberships.

To align traditional Medicare with the engagement structures seen in MA and commercial insurance, Congress should authorize direct financial incentives for Medicare beneficiaries who take proactive steps to improve their health. These incentives could mirror existing MA incentives by including lower cost-sharing, reduced premiums, or rewards for completing preventive screenings, participating in chronic disease management programs, or adopting healthy lifestyle changes.

Waive Medicare cost-sharing requirements for chronic care and chronic care management services

Under traditional Medicare, beneficiaries are responsible for deductibles, coinsurance, and copayments for most services. While some preventive services—such as screenings for cancer, diabetes, and heart disease—are exempt from cost-sharing, patients still incur costs for necessary follow-up tests and ongoing care.

These costs can be particularly burdensome for individuals with chronic conditions or complex healthcare needs. Medicare Part B's structure stands in contrast to the private insurance market, where insurers more frequently employ financial incentives such as reduced premiums and lower cost-sharing to promote patient engagement.

---

[1] Taber JM, Leyva B, Persoskie A. Why do people avoid medical care? A qualitative study using national data. J Gen Intern Med. 2015 Mar;30(3):290-7. doi: 10.1007/s11606-014-3089-1. Epub 2014 Nov 12. PMID: 25387439; PMCID: PMC4351276

[2] https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/downloads/bip-guidance.pdf

AMGA providers report that patient engagement improves when cost-sharing requirements do not serve as an obstacle to care. Reducing financial barriers can increase uptake of preventive services, follow-up visits, and chronic disease management —key elements of effective care delivery.

The U.S. Preventive Services Task Force (USPSTF) plays a vital role in guiding preventive care through evidence-based recommendations on screenings, counseling, and services. Under the Affordable Care Act (ACA), private health plans are required to cover USPSTF-recommended preventive services with no cost-sharing.[3] However, the USPSTF's scope focuses primarily on early detection and risk reduction, rather than ongoing management and treatment of chronic diseases.

While early diagnosis is essential, chronic conditions such as diabetes, hypertension, and heart disease require continuous, coordinated care. Effectively addressing chronic disease demands broader strategies that include coordinated care teams, patient education, lifestyle support, and access to affordable treatment.

AMGA views the USPSTF recommendations as a valuable foundation, but emphasizes the need for policies and care models that prioritize long-term disease management. AMGA recommends eliminating cost-sharing for chronic disease management services, including regular screenings, follow-up appointments, and preventive interventions. By reducing costs for patients with chronic conditions, we can increase engagement and reduce avoidable, high-cost health events.

Medicare reimburses clinicians for non-face-to-face chronic care management (CCM) under a separately billable code in the Medicare Physician Fee Schedule (MPFS) for beneficiaries with two or more chronic conditions. However, any value a beneficiary receives is offset by a 20% coinsurance obligation for patients, establishing an unexpected and unavoidable barrier to care.

> *"Patients who have been receiving care management services for free are reluctant to start paying. Patients also are apprehensive about their copayment for this program and are reluctant to enroll."*
>
> — **Beth Averbeck, MD, FACP,** *Senior Medical Director, Primary Care, HealthPartners*

Out-of-pocket expenses often discourage patients from consenting to CCM services. By removing cost-sharing barriers, Congress would incentivize patients to participate in regular care coordination, medication management, and preventive interventions—reducing the risk of costly complications and hospitalizations. Eliminating CCM cost-sharing also aligns with high-value care principles that favor proactive management over reactive treatment. AMGA previously endorsed the Chronic Care Management Improvement Act of 2023, which would waive cost-sharing for CCM services.[4]

Permanently remove geographic and originating site restrictions for telehealth

Technological advancements offer powerful opportunities for patients to engage with healthcare providers from the comfort of their homes. As noted in the "Improving Health Outcomes through High-Value Care" section of this report, transportation remains a major barrier to care—especially for those in rural or underserved areas, individuals with limited mobility, or people without reliable vehicle access. Transportation-related challenges often lead to missed appointments, increased emergency department use, and higher out-of-pocket costs. These financial and logistical burdens can be a disincentive for patients from seeking care altogether.

---

[3] Sec. 2713 of the Affordable Care Act

[4] https://www.amga.org/about-amga/newsroom/press-releases/2024/april/amga-endorses-chronic-care-management-reform

Telehealth and digital health tools can help bridge these gaps by improving accessibility and reducing travel-related costs. Telehealth allows patients to connect with healthcare providers through video calls, phone consultations, or messaging apps—facilitating continuity of care without the need for physical visits.

For patients in rural communities, telehealth can connect them with specialists or healthcare providers otherwise unavailable locally. This access is vital for individuals who would otherwise need to travel long distances for specialized care.

Fund digital health navigators to bridge the digital divide

To enhance patient access and engagement in digital healthcare, reimbursing medical groups and health systems for employing digital health navigators is essential. These navigators assist patients in utilizing telehealth platforms, understanding health data, and engaging with remote monitoring tools, ensuring that technology serves as an enabler rather than a barrier. By providing guidance on digital tools, navigators help patients overcome challenges related to digital literacy and connectivity, particularly in underserved communities. This support not only facilitates the effective use of telehealth services, but also promotes equitable access to care.

Digital health tools, including wearable devices and mobile health applications, also enable remote monitoring of vital health metrics such as blood pressure, glucose levels, and heart rate. This continuous monitoring allows for early detection of health issues and timely interventions, reducing the need for frequent in-person visits and associated costs. Remote Patient Monitoring (RPM) further enhances chronic disease management by providing real-time data to healthcare providers, supporting better treatment adherence, reducing hospitalizations, and improving care coordination. Integrating digital health navigators into care teams, alongside the adoption of RPM technologies, can significantly improve clinical outcomes and make healthcare more affordable and accessible for all patients.

Mandate data sharing from commercial payers to providers

To deliver high-quality, coordinated care, providers need access to commercial claims data. These data—submitted by insurers—offer a comprehensive view of a patient's healthcare utilization, treatments, and cost patterns across settings. Unlike electronic health records, which reflect only the care delivered by a specific

Dr. Eric Wallace's Testimony on Rural Healthcare Access Challenges in Demopolis, AL, before the Senate Finance Committee

In many cases, telehealth provides better care than the previous in-person alternative. Previously, if a dialysis patient arrived at Demopolis with life-threatening high potassium, they were given a medicine to remove the potassium through the stool.

The patient would then be put in an ambulance and transported to the nearest dialysis-ready hospital, which would take at least 90 minutes. The ambulance had to wait at the hospital while the patient waited on a bed, and finally, around 8 to 12 hours later, the patient would be dialyzed. It was the best we could do at the time. But this was a disservice to the patient.

An ambulance is used each time a patient is transferred to a larger center from Demopolis. Marengo County, Alabama, only has three ambulances, so if two patients were being transferred due to a lack of local services, that leaves only one ambulance to cover the whole county. With telehealth, we are able to do a nephrology consult on the patient in Demopolis; the rural hospital keeps the patient, and we are able to start dialysis within one hour of the patient's arrival.

— **Eric Wallace, MD**, *Professor of Medicine in the Division of Nephrology and Medical Director, UAB Health System Telehealth Program* provider, claims data capture services performed elsewhere, such as preventative screenings, diagnostic tests, and emergency care. AMGA's annual risk survey consistently identifies lack of access to claims data as an obstacle to high-value care.[5]

Incorporating these additional data would offer a more complete, "real-time" picture of the patient's health journey. This would reduce unnecessary procedures, minimize duplicative testing, and lower the overall cost of care.

Claims data also enable providers to go beyond episodic care and manage care holistically. They reveal past diagnoses, medications, and interactions with other healthcare professionals—critical for managing patients with complex or chronic conditions. With this full picture, providers can identify care gaps, such as missed preventive screenings, and foster shared decision making with both patients and clinicians to reduce the risk of conflicting treatments or adverse medication interactions.

Beyond individual care, claims data strengthen population health management and support high-value care models. They enable providers to analyze trends, predict risks, and allocate resources effectively. This data-driven approach improves patient outcomes while supporting systemwide efficiency and cost containment.

Benefits of Remote Patient Monitoring

"Advocate Hospital at Home enables patients to receive at home, hospital-level care with hospital-level monitoring overseen by nurses. For the appropriate patients, this allows quicker recovery in a familiar setting surrounded by family."

— **Elisabeth Stambaugh, MD, MMM**, *Chief Medical Officer, Wake Forest Health Network, Atrium Health Wake Forest Baptist*

Conclusion

Fostering meaningful patient engagement is key to improving patient outcomes and transitioning to a high-value care system. AMGA believes this requires a comprehensive strategy built around aligning financial incentives and eliminating structural barriers. Key challenges—such as health literacy disparities, lack of data transparency, and unequal access to care—must be addressed.

Congress must recognize how financial burdens, confusing billing practices, and restricted access to information hinder patients from fully engaging in their care. By promoting financial incentives, expanding digital access, improving transparency, and enhancing patient education, lawmakers can modernize the healthcare system and empower patients to become active participants in their health.

---

[5] 2025 AMGA Issue Brief on Access to Claims Data available at www.amga.org/getmedia/817d6dc2-bc6a-4179-a18e-e052935bfdbd/2025-access-to-claims-data-issue-brief.pdf

Improve Health Outcomes Through High-Value Care

AMGA Goal

Improve health outcomes through a multifaceted approach that empowers patients, eliminates barriers to access, promotes coordinated and patient-centric care, and supports high-value care models. Reforms must focus on systematic improvements that create improved health outcomes, rather than on separate and distinct efforts.

AMGA strongly supports efforts to help providers address our nation's chronic disease crisis by targeting disparities that disproportionately affect health outcomes across various populations and geographic locations. With a comprehensive approach that embeds appropriate goals and incentives into care models and provides greater integration of necessary systems, we can work to ensure healthcare is accessible, effective, and tailored to meet the needs of every beneficiary. By reducing disparities driven by factors including race, ethnicity, socioeconomic status, and geographic location, we can make America healthier, increasing life expectancy while reducing healthcare costs.

Healthcare providers play a critical role in addressing chronic disease and its associated poor health outcomes, but it is essential for policymakers to recognize healthcare systems cannot solve this crisis alone. Within the healthcare industry, it is widely recognized that up to 80% of health outcomes are linked to issues outside the control of healthcare providers and require broader societal interventions.[1] The healthcare system is currently tasked with treating illnesses and managing health conditions, but social drivers of health—such as housing, education, food security, transportation, and economic stability—heavily influence health outcomes. For example, a patient with diabetes may receive high-quality medical care, but lack access to affordable, nutritious food or safe spaces for physical activity. Even if such patients receive optimal medical care, their health might still deteriorate due to their underlying environmental circumstances. Expecting healthcare providers to solve systemic issues without addressing underlying

AMGA: Improving Care for All

AMGA Foundation launched an effort to address atherosclerotic cardiovascular disease (ASCVD) care.

The ASCVD Best Practices Learning Collaborative joins a long list of initiatives by AMGA Foundation to help medical groups improve the care of patients with chronic conditions and preventable illnesses.

Participants describe challenges they have faced and overcome, ways to share and scale solutions, and tactics for developing potential innovations.

By compiling evidence of best practices, these initiatives seek to establish standards for optimal care.

AMGA reviewed the data for each participating group and found women with ASCVD were 10-15% less likely to be getting appropriate care for their condition, namely a prescription for a statin.

---

[1] Magnan, S. 2017. Social Determinants of Health 101 for Health Care: Five Plus Five. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC.

socioeconomic drivers places an unrealistic burden on the system and its workforce. More importantly, these efforts are unsustainable and ultimately unsuccessful.

Despite these challenges, AMGA represents thousands of providers who understand the vital and instrumental role our healthcare system plays in addressing these disparities and dismantling the chronic disease epidemic.

To help the provider community best serve the American public, AMGA recommends that Congress integrate health outcomes into policy decisions, program design, and healthcare delivery models by pursuing the following:

- **Support providers' ability to address larger societal challenges as an aspect of high-value care**: Empowering healthcare providers to tackle broader societal issues—such as housing instability, food insecurity, and transportation barriers—can lead to more comprehensive and effective patient care. By integrating social drivers of health into care plans, providers can improve health outcomes and reduce long-term healthcare costs.
- **Standardize metrics, technology, and payment models to promote optimal outcomes**: Implementing uniform quality metrics, interoperable technologies, and consistent payment structures enables healthcare systems to better measure performance, enhance care coordination, and incentivize high-value care.
- **Expand community resources to address barriers to care**: Investing in community-based services—such as mobile clinics, telehealth access points, and health education programs—can mitigate barriers like geographic isolation, lack of transportation, and limited health literacy. Enhancing these resources ensures all populations can access high-quality care.

Support providers' ability to address larger societal challenges as an aspect of high-value care

High-value care encourages providers to adopt interventions to support patient health holistically, considering both the medical and nonmedical needs that impact well-being. To further these goals, targeted policies and reimbursement structures are essential to ensure patients receive the specific attention and care they need based on their individual circumstances. This can be achieved through appropriate payment adjustments, tracking population health outcomes, and offering financial incentives to patients.

Payment adjustments that account for patient characteristics, such as socioeconomic status or geographic location, ensure providers have the resources they need to care for all communities and provide access to high-quality care. Higher reimbursement rates for addressing disparities or managing complex care needs support the ability of healthcare providers to treat patients' immediate care needs, while also collaborating with patient navigators and community-based organizations to manage non-healthcare needs that significantly impact a patient's overall well-being. Federal policy should emphasize performance metrics that track population health outcomes. Timely and relevant data can empower providers to provide targeted interventions that address gaps in care. In addition, financial incentives for patients to engage and maintain their health help patients adopt healthier behaviors, drive appropriate engagement with providers supporting their health, and reduce barriers to care.

High-value care can serve as a powerful tool to improve health outcomes by aligning financial incentives with improved patient outcomes. When policymakers create payment structures that empower providers to deliver holistic, person-centered care and allow flexibility in treatment approaches, providers will be better equipped to address social drivers of health and improve health outcomes.

Standardize metrics, technology, and payment models to promote optimal outcomes

The shift to high-value care is hindered by critical gaps in infrastructure and data integration. Without the appropriate foundation, how can we expect the system to remain stable or improve?

The absence of a robust, standardized data infrastructure limits providers' ability to capture, analyze, and act on essential information. Inconsistent data systems hinder the ability to monitor progress, identify disparities, and ensure care delivery is delivered as efficiently and effectively as possible. Without integrated technology and comprehensive data collection, high-value care's potential to improve outcomes remains untapped.

Compounding this issue is the lack of standardized metrics and comprehensive reporting mechanisms at the state and national levels. While high-value care models aim to address disparities, the absence of transparent, standardized metrics makes it difficult to assess whether interventions are effective and identify where gaps in care still exist. According to a 2024 NAACOS white paper, ACOs frequently cite difficulties integrating disparate electronic health record (EHR) systems and aligning data from multiple payers as a core barrier to effectively using data to drive high-value care.[2]

Potential solutions to modernize our data infrastructure include:

- Ensuring adequate federal funding for health IT systems, including mandated upgrades necessary to comply with new or revised regulatory requirements, as required by the 21st Century Cures Act (Cures Act) and the Health Information Technology for Economic and Clinical Health (HITECH) Act
- Supporting interoperability standards across payers and providers
- Establishing comprehensive health metrics to enable healthcare organizations to compare health outcomes across national benchmarks

By enhancing systems that can track and measure health outcomes, healthcare providers will gain actionable insights, enabling more informed decision making to better target interventions and address disparities.

Expand community resources to address barriers to care

Healthcare providers cannot drive change alone. To meet patients where they are, especially in underserved and historically marginalized communities, systems must be empowered to

Dr. Paul Pritchard on the Importance of Addressing the Needs of the Underserved

Through initiatives like the Colorectal Cancer Screening Best Practices Learning Collaborative led by AMGA, we have consistently integrated goals into our quality metrics to ensure that all patient populations receive appropriate preventive care. This includes developing targeted registries and outreach programs aimed at increasing screening rates among underserved groups.

However, the financial challenges brought on by the COVID-19 pandemic, coupled with limited funding and incentives for such programs, have impacted our capacity to maintain dedicated focus on these efforts. But we remain committed to embedding these objectives into our broader organizational strategies and continuing to prioritize inclusive, patient-centered care.

— **Paul Pritchard, MD, MBA**, *Vice President and Chief of Quality, Prevea Clinic*

---

[2] NAACOS. 2024. ACO drivers for success: Lessons from high-performing accountable care organizations. National Association of ACOs. www.naacos.com/wp-content/uploads/2024/09/ACODriversForSuccessWhitePaper.pdf

partner with community-based organizations, patient navigators, and trusted local leaders. These partnerships enable providers to extend their reach beyond the clinical setting and connect patients with the resources they need to thrive.

Embedding community health workers and patient navigators into care teams is especially critical. These individuals bridge the gap between providers and patients, helping navigate care, build trust, and ensure cultural and linguistic alignment. For example, patient navigators can ensure adherence to care plans by coordinating with community-based organizations that support transportation, nutrition, and adequate housing concerns for patients. Their presence not only reduces logistical barriers, but also helps tailor care to the unique needs of each community.

Federal models like the Accountable Health Communities Model have shown promise in aligning clinical care with social services, but widespread impact depends on adequate funding, policy flexibility, and long-term sustainability. Expanding and scaling these types of initiatives is essential to achieving the goal of transforming healthcare into a truly accountable ecosystem.

Conclusion

Ultimately, achieving optimal health outcomes requires both a well-supported healthcare system and the active involvement of non-health sectors. Policymakers must strike this balance, enabling the healthcare system to focus on what it does best—providing care—while fostering cross-sectoral collaboration to address the root causes of health disparities and chronic disease. Without this balance, efforts to advance optimal health outcomes for all populations may falter, leaving our nation to continue bearing the burden of preventable health disparities.

Wendy Ferrell-Smith on the Importance of Addressing Social Drivers of Health

Our high-value care team utilized reporting from our payers to identify patients with confirmed and predicted social drivers of health (SDOH) who were in the doughnut hole and on branded medications. These patients are statistically more likely to suffer from non-adherence, leading to increased utilization. We proactively reached out to these patients using both social workers and certified pharmacy technicians to offer help with navigating patient assistance programs. We processed 219 applications, of which 142 were approved, resulting in $771,164 in savings in 2024 to the service pool for Medicare patients. These same patients, once renewed, will lead to $1,222,925 saved in 2025. Patients on assistance programs have no cost to their medications, which in turn removes the financial SDOH barrier and contributes to the health equity in our patient population.

— **Wendy Ferrell-Smith, MHI, BSN, CCM**, *Chief Value Based Care Officer, Summit Medical Group*

Case Study:

Addressing Health Outcomes Challenges at Northwell Health

Northwell Health, the largest employer in the state of New York, is committed to improving health outcomes and reducing disparities within its diverse patient population. While its mission prioritizes advancing health equity, the organization faces challenges related to standardized metrics, technological integration, and infrastructure for addressing social drivers of health. These barriers reflect broader systemic issues, underscoring the complexities of achieving health equity in high-value care models.

Background

Northwell Health serves patients from a highly diverse geography from varied socioeconomic and cultural backgrounds. The health system has recognized the critical role of addressing social drivers of health, which can account for up to 80% of health outcomes. However, without comprehensive standardized metrics, robust data systems, and seamless technology integration, efforts to implement equity-driven interventions face limitations.

Challenges

1. **Lack of Standardized Metrics for Equity**

   Northwell Health has struggled with the absence of consistent health equity metrics, a common issue among healthcare systems transitioning to high-value care. Without standardized health equity metrics, it becomes difficult to measure disparities, assess progress, and compare outcomes across populations. For example, each high-value care contract or arrangement has slightly different attribution models or focuses within the health equity space. It makes it difficult to apply universal approaches to addressing gaps in care through a population health lens. Instead, health systems have to focus on the overlap, as addressing all metrics in every contract becomes too burdensome from a resource perspective.

2. **Fragmented Technology Infrastructure**

   As Northwell Health moved toward digital transformation, gaps in technology integration emerged as a significant barrier. Legacy systems, coupled with disparate electronic health record (EHR) platforms, hindered the seamless flow of patient data across care settings. The fragmentation makes it difficult to view data across an entire system. For example, information is typically shared through spreadsheets or added to a data warehouse, which requires significant resources and technical expertise. This process leads to fragmentation, limiting the organization's ability to effectively coordinate care and address nonmedical needs, such as housing, transportation, and food security.

3. **Challenges in Data Collection and Utilization**

   Robust data collection is essential for identifying health disparities and developing targeted interventions. However, Northwell Health encountered difficulties in capturing comprehensive social drivers data within its EHR systems. Each EHR system typically has its own workflows and screening tools. To ensure consistency, significant effort is needed to standardize the work. Ramsey Abdallah, assistant vice president of quality at Northwell Health, added, "We are undergoing a significant review of our systems to standardize where possible. This will enable us to obtain the granular data needed to analyze trends and better address the unique needs of vulnerable populations." He went on to add, "The bigger challenge will come with the training and implementation of the new workflows. Given our geographic region and its diversity, we have to tailor our approach to the local community."

4. **Limited Interoperability**

   Northwell Health's efforts to collaborate with external partners, such as community organizations and public health agencies, were constrained by interoperability issues. For example, when a social driver such as food insecurity is identified, a referral can be made to a community-based organization. They can easily track the number of referrals, but the current system makes it difficult to detect if the referral loop was closed and if the issue was addressed. In the current state, most of this information is exchanged through spreadsheets, emails, or other non-digital, non-automated methods. These challenges prevented the effective exchange of critical patient data, further complicating efforts to address health inequities holistically.

Strategies and interventions

Despite these challenges, Northwell Health has made concerted efforts to overcome systemic barriers and embed health equity into its care delivery models. Key strategies include:

1. **Investing in Health IT Systems**

   Recognizing the limitations of its existing technology infrastructure, Northwell Health prioritized investments in interoperable health IT systems. The health system has elected to migrate to Epic as the enterprise solution. By adopting a single EHR, they are able to capitalize on Epic's enhanced capabilities and more easily build integrations of social driver data. This is driven by the fact that there would be fewer external integrations needed and that Epic has established integrations already available. Northwell Health hopes this will accelerate their ability to gain actionable insights into patient needs and disparities.

2. **Collaborating with Community Partners**

   To address gaps in care, Northwell Health expanded partnerships with community organizations focused on housing, nutrition, and transportation. For example, they have partnered with Island Harvest, Long Island Cares Inc., The Harry Chapin Food Bank, God's Love We Deliver, US Foods, and Baldor to start Food as Health, which helps communities deemed as "food deserts" by delivering healthy foods to homes where residents are hampered by chronic illness due to poor nutrition. Northwell Health is also collaborating with Chicago-based startup NowPow to utilize a platform that connects patients to community-based organizations, as well as with Harlem Grown, a network of urban farms providing underserved children with the skills and knowledge to produce sustainable and healthy food for their families and community. More recently, Northwell Health has continued its efforts to expand access to nutritious food by partnering with InstaCart Health. The leading grocery technology company in North America provides tools and resources to Northwell Health staff, patients, and communities that address social drivers of health, including access to healthy food and transportation. These collaborations enabled the health system to connect patients with essential resources and mitigate nonmedical barriers to health.

3. **Embedding Equity Metrics in High-Value Care Models**

   Northwell Health has advocated for the inclusion of health equity metrics in high-value care reimbursement structures. By tying financial incentives to equitable outcomes, the organization seeks to ensure that underserved populations receive the targeted care they need. Additionally, Northwell Health has embedded health equity into its internal dashboards and applies a health equity lens to system priorities. A key example is the Accountable Care Organization (ACO) metrics, through which they track and trend performance by race, ethnicity, and preferred language. By trending data through an equity lens, the organization is better able to identify potential gaps, even in metrics that appear to be performing well in aggregate.

4. **Training and Capacity Building**

   To support these initiatives, Northwell Health implemented staff training programs focused on culturally competent care and the collection of equity-related data. The organization is committed to building a workforce ready to address the challenges of tomorrow. These efforts align with the organization's broader goal of fostering an inclusive and responsive care environment.

Outcomes and lessons learned

While challenges persist, Northwell Health's efforts to integrate equity into its operations have yielded promising outcomes. Improved data collection processes have enabled the organization to identify disparities more effectively and develop targeted interventions. For example, through the integration of health equity data, Northwell Health has been able to identify practices in select ZIP codes where hypertension control rates are lower, enabling the team to design targeted interventions to that community. Additionally, partnerships with community organizations have strengthened Northwell Health's ability to address social drivers of health at scale.

Key lessons from Northwell's experience include the importance of:

- Standardizing equity metrics to ensure consistent measurement and accountability
- Investing in interoperable technology systems that facilitate seamless data sharing
- Engaging community partners to address social drivers of health comprehensively
- Advocating for policy reforms that align financial incentives with equitable outcomes

Conclusion

Northwell Health's journey highlights the complexities of advancing health equity in a fragmented healthcare landscape. While systemic barriers related to measurement, technology, and integration remain significant, the organization's commitment to high-value care provides a strong foundation for driving equitable outcomes. By addressing these challenges through targeted investments, collaborations, and advocacy, Northwell Health continues to serve as a model for other healthcare systems navigating similar obstacles.

Protect Patient Dignity at End of Life

AMGA Goal

Safeguard the dignity and wishes of patients by facilitating open conversations about desired end-of-life medical care and goals and by ensuring benefit designs and models of care enable patients to receive this care in a manner respecting their wishes.

AMGA values the importance of respecting patient wishes as they approach death. To respect the dignity and needs of patients nearing the end of life, AMGA recommends Congress take a holistic approach to improving end-of-life care for Americans by enhancing and improving Medicare coverage for end-of-life care, supporting education and outreach efforts for patients and their families, and engaging with the non-healthcare community to support patients in their communities at the end of life.

End-of-life care encompasses both palliative care, which alleviates suffering for patients undergoing treatment, and hospice care, which focuses on providing comfort for those facing terminal illnesses. Distinguishing between palliative care and hospice care is essential. Palliative care focuses on alleviating suffering and improving the quality of life for patients undergoing treatment for serious illnesses, regardless of their prognosis. Palliative care often is provided alongside curative treatments and addresses symptoms like pain, nausea, and fatigue across various stages of illness. In contrast, hospice care is specifically designed for terminally ill patients who are nearing the end of life and forgo curative treatments in favor of quality of life. The primary aim of hospice care is to provide comfort and to support patients and their families through an approach that addresses physical, emotional, and spiritual care. Both forms of care prioritize comfort but serve patients at different stages, with hospice care reserved for those nearing life's end.

Why End-Of-Life Care?

About 15 to 20 years ago, I admitted an elderly gentleman four times to the hospital in a six-month period. After he subsequently died of heart failure, his family approached me and thanked me for taking care of their loved one. Their only regret was the "suddenness" of his passing.

I felt very small at the point. Their loved one had been slowly dying from the day we met, as he had heart failure, and the only thing I could do was tweak medications when he had a brat during the Packer's game. But I failed to prepare them, as I had tunnel vision and was treating symptoms and not the patient.

— **Paul Pritchard, MD, MBA**, *Vice President and Chief of Quality, Prevea Clinic*

Understanding and distinguishing these forms of care is vital for improving patient experiences and outcomes. End-of-life care involves providing medical, emotional, and supportive services to individuals nearing life's end, aiming to enhance their quality of life and uphold their dignity.

The current landscape of end-of-life care is influenced by Medicare Hospice Benefit's per diem reimbursement and six-month prognosis criteria, which is based on hospice's traditional focus on cancer patients. This focus, however, is shifting due to changing patient demographics, as hospice patients are increasingly diagnosed with non-cancer conditions.

AMGA recommends Congress:

- **Establish a Total-Cost-of-Care Model for End-of-Life Care**: Develop a comprehensive framework that encompasses all aspects of care delivery and reimbursement to address the holistic needs of patients.
- **Engage Community and Non-Healthcare Stakeholders**: Support partnerships with community organizations to foster collaborative discussions that broaden support for end-of-life care. Engaging various stakeholders promotes a more inclusive dialogue around patient preferences and needs.
- **Implement Outreach and Education Programs**: Launch initiatives involving healthcare providers, community leaders, and advocates to create a supportive environment for end-of-life care discussions. These programs empower patients and families to make informed decisions about care options.
- **Expand Medicare Coverage for End-of-Life Care**: Adjust fee-for-service models to better account for advanced illness planning and care coordination services. Additionally, build on existing models to include individuals who do not require nursing home-level care, offering broader comprehensive support for those facing serious health challenges.

Establish a total-cost-of-care model for end-of-life care

The integration of end-of-life care into high-value care models has emerged as a vital component in the effort to transform healthcare systems, ensuring that patients receive compassionate and respectful care during their final days. AMGA supports this initiative by advocating for policies that prioritize patient-centered approaches to end-of-life care. This integration honors the dignity and wishes of individuals, while addressing the distinct needs of an aging population.

Incorporating end-of-life care within high-value care models not only meets patients' emotional and physical needs but also supports health system efficiency. By encouraging open discussions among providers, patients, and families, patients are empowered to make informed choices that align with their preferences. Benefits of prioritizing end-of-life care within high-value care frameworks include increased patient satisfaction, better resource management, and lower costs associated with hospitalizations and aggressive interventions. Further, palliative care improves quality of life for patients and their families, while also avoiding unnecessary care.[1] Congress has previously considered the importance of such advanced care planning, and AMGA strongly encourages Congress to build on its previous work.[2]

Integrating end-of-life care within high-value care frameworks presents challenges. Many providers lack necessary training to engage in meaningful conversations about patients' goals and preferences. Additionally, existing

---

[1] World Health Organization Fact Sheet on Palliative Care, August 5, 2020

[2] "Collins, Warner Introduce Bipartisan, Bicameral Legislation to Expand Access to Advance Care Planning," Nov. 24, 2022. www.collins.senate.gov/newsroom/collins-warner-introduce-bipartisan-bicameral-legislation-to-expand-access-to-advance-care-planning

reimbursement models often fail to address the complexities of end-of-life care, which can lead to misaligned priorities in care delivery. To address these challenges, AMGA urges Congress and stakeholders to develop and adopt comprehensive policies that embed end-of-life care principles into high-value care models, ensuring that all patients receive the care they desire and deserve.

The shift in patient demographics presents an opportunity to reassess and modernize current models to better address complex, varied needs through expanded palliative care access, earlier intervention, and high-value care models. Partnerships between hospice providers and Accountable Care Organizations (ACOs) could further enhance care coordination, align financial incentives with patient-centered goals, and improve outcomes.

To advance this effort, AMGA recommends the Centers for Medicare & Medicaid Services (CMS) develop a total-cost-of-care model that goes beyond traditional payment structures and directly reimburses providers for engaging in meaningful conversations with patients and their families. These discussions would help facilitate informed decisions about palliative care options and hospice enrollment, ensuring that care aligns with patients' values and preferences. A total-cost-of-care model should represent a holistic framework that integrates all aspects of care delivery, quality measures, and reimbursement strategies to address the complex needs of end-of-life patients as comprehensively as possible. Such a model could build on the Medicare Care Choices Model, which found "some terminally ill Medicare beneficiaries will accept supportive and palliative care services if they do not have to forgo payment for the treatment of their terminal conditions."[3]

Engage community and non-healthcare stakeholders

Congress and CMS should engage community organizations, faith-based groups, and other non-healthcare stakeholders to foster a more comprehensive and culturally sensitive approach. Community organizations are often trusted entities and can serve as effective liaisons for educating individuals about palliative care options and advanced care planning. Congress and CMS can expand awareness campaigns that resonate with diverse populations by providing grants and partnerships to these organizations. Faith-based groups, for example, can play a crucial role in addressing cultural and spiritual concerns related to end-of-life decision-making, helping families navigate these complex conversations with a foundation of trust.

Non-healthcare stakeholders, such as legal aid services, can also contribute to end-of-life care improvements by addressing ancillary needs that affect quality of life. For example, legal organizations can assist individuals in creating advance directives or wills, ensuring their healthcare preferences are honored. Businesses can offer employee education programs on caregiving and bereavement support, fostering a culture of understanding around end-of-life issues. By creating collaborative networks that incorporate these diverse stakeholders, Congress and CMS can broaden the scope of end-of-life care beyond traditional healthcare settings, ensuring that patients and their families receive holistic and community-centered support.

Implement outreach and education programs

Congress and CMS can significantly improve the quality and accessibility of end-of-life care by implementing comprehensive outreach and education programs that empower patients, families, and healthcare providers to make informed decisions. These programs should aim to raise awareness about the importance of advance care planning, including tools such as living wills, healthcare proxies, and documented care preferences. Such initiatives could include public education campaigns to normalize conversations about end-of-life care, addressing cultural stigmas and fostering an understanding of hospice and palliative care services.

---

3. Medicare Care Choices Model, Fifth and Final Annual Evaluation Report

For healthcare providers, CMS should fund and support training programs designed to enhance communication skills, ensuring clinicians feel confident and equipped to engage in sensitive discussions about prognosis, treatment options, and patient values. Education efforts should support shared decision making and explain the efficacy of treatment options and how futile efforts negatively affect quality of life. Outreach efforts should leverage technology, such as telehealth platforms, and community partnerships to deliver resources to diverse populations, particularly in underserved or rural areas. Multilingual materials and culturally tailored content would be critical to ensuring equitable access to these educational opportunities. While there is some federal support for caregivers, it is largely restricted to Medicaid or veterans programs.

Federal support for caregivers also is an economic necessity. The financial and emotional toll on caregivers is substantial, often leading to reduced workforce participation and increased reliance on public assistance. Investing in caregiver support programs can yield significant economic benefits by enabling caregivers to remain in the workforce and reducing their financial strain. Supporting caregivers also helps maintain their health and well-being, potentially reducing healthcare costs associated with hospitalizations and institutional care. As the population ages, the demand for caregiving will only grow, making federal investment in caregiver support both a compassionate choice and a strategic economic decision.

Additionally, Congress should allocate funding to pilot programs that integrate end-of-life care discussions into routine care, such as Annual Wellness Visits, during which clinicians can assess and document care preferences early. By fostering an informed, patient-centered approach, these initiatives can reduce unnecessary interventions, align care with individual values, and ultimately improve patient and family satisfaction, while also alleviating the emotional and financial burdens often associated with end-of-life care.

Benefits of Palliative Care

A Wisconsin nonprofit hospice and palliative provider and partner of an AMGA member conducted an analysis of an aggregate of 160 patients who were in their palliative program in 2022.

These 160 patients had 181 ER visits during the 6 months prior to admitting into their program. These same patients had only 57 ER visits for the 6 months after program admission.

- ER reduction of 69%.
- This is savings of $558,000 based on an average cost per ER visit of $4,500 (Data source: WHA price point)

These same 160 patients had 119 hospitalizations during the 6 months prior to program admission and only 38 hospitalizations for the 6 months after admission.

- Hospitalization reduction of 69%

This represents savings of $2,976,021 to the Medicare program, based on an average cost per hospitalization of $36,741.

Expand Medicare coverage for end-of-life care

Expanding Medicare coverage for end-of-life care would ensure patients and families receive comprehensive, compassionate, and equitable support during a critical stage of life. Current Medicare benefits for hospice and palliative care provide valuable services, but often fall short in addressing the full spectrum of patients' needs, such as earlier access to palliative care and broader coverage for innovative care delivery models. To address these gaps, Congress should amend Medicare policies to include more flexible eligibility criteria for hospice, allowing patients to receive concurrent curative and palliative treatments. This approach, along with improved reimbursement to ensure palliative care and hospice care is appropriately reimbursed, would help align care with patient preferences and reduce the difficult choice between seeking life-prolonging treatments and receiving comfort-focused care. Currently, Medicare reimbursement does not adequately cover the infrastructure, such as triage nurse and transportation services, needed to provide palliative and hospice care. Historically, AMGA members report these services only survive through subsidies from other service lines and community philanthropy.

Additionally, Medicare should expand reimbursement for caregiver support, mental health counseling, and bereavement services to ensure that families have the resources they need. Telehealth should also be fully integrated into end-of-life care coverage, enabling patients in rural or underserved areas to access palliative care specialists without traveling. Furthermore, expanding pilot programs like the Medicare Care Choices Model, which allows patients to receive palliative services alongside standard treatments, could provide valuable insights into sustainable ways to improve care quality while managing costs. Congress and CMS should build on the Program of All-Inclusive Care for the Elderly (PACE) model of care, which provides comprehensive medical, emotional, and supportive services to help seniors remain in their communities. PACE is based on the idea that most older adults prefer to receive care at home rather than in a nursing home. Currently, Medicare reimburses PACE at a capitated rate for beneficiaries identified by the state as needing nursing home-level care. AMGA recommends CMS expand coverage of the PACE model to allow more individuals access to essential end-of-life care, particularly for patients receiving palliative but nonterminal care. This approach reflects a nuanced understanding of end-of-life needs, allowing comfort-focused care regardless of terminal status. AMGA is also optimistic about the Guiding an Improved Dementia Experience (GUIDE) Model, a voluntary nationwide model test that aims to support people with dementia and their unpaid caregivers.

By broadening Medicare coverage, policymakers can help create a healthcare system that prioritizes dignity, comfort, and patient-centered decision making at the end of life.

Conclusion

Addressing end-of-life care is fraught with difficulties, but AMGA contends it is a vital aspect of any serious effort to improve Medicare from both a beneficiary coverage and a provider reimbursement standpoint. Many patients nearing the end of life undergo invasive and expensive interventions—such as feeding tubes and dialysis—that often offer little benefit in terms of extending life or enhancing its quality. Although most individuals express a preference to spend their final days at home, many still die in hospitals or nursing facilities after experiencing multiple transitions between care settings. Bereaved family members frequently report shortcomings in end-of-life care, including inadequate pain control for 25% of patients, high rates of emotional distress (56% experienced anxiety or depression), and unmet spiritual needs for more than 40% of decedents.[4] Medicare spends roughly 25% of its total budget on patients in their final year of life, with median spending during the last six months exceeding $25,000 in many regions.[5] Engaging patients, families, and friends in this journey empowers individuals, providing comfort during life's final stage. The future of end-of-life care should prioritize patient-centered principles, ensuring compassionate, dignified care. By developing a total-cost-of-care model, engaging diverse stakeholders, expanding education and outreach, and enhancing Medicare coverage, policymakers, providers, and stakeholders can collectively ensure individuals receive the highest quality end-of-life care.

---

[4] Nicholas LH, Fischer SM, Arbaje AI, Perraillon MC, Jones CD, Polsky D. Medicare-Covered Services Near the End of Life in Medicare Advantage vs Traditional Medicare. JAMA Health Forum. 2024;5(7):e241777. doi:10.1001/jamahealthforum.2024.1777

[5] Ibid

Remove Regulatory and Legislative Barriers to High-Value Care

AMGA Goal

Ensure patients receive coordinated, patient-centric care in the most appropriate settings by removing regulatory and statutory obstacles to care delivery and provider operations.

In recent years, Congress and the Centers for Medicare & Medicaid Services (CMS) have worked to remove the barriers and obstacles that prevent medical group practices and integrated systems of care from delivering the highest quality care in the most efficient and cost-effective way. AMGA recommends building on these efforts by continuing to modernize Medicare laws and regulations to support care delivery patterns which have evolved since Medicare's inception.

Despite reforms, such as Medicare Access and CHIP Reauthorization Act of 2015, and a variety of demonstrations, Medicare laws and regulations remain rooted in the healthcare delivery model prevailing in 1965 when the program was enacted. At that time, Medicare's structure and rules reflected current care standards, which emphasized acute care delivered in hospitals or individual physician practices. These regulations, while appropriate for the era, do not fully account for the modern realities of healthcare, such as the rise of team-based care, the shift toward outpatient and home-based services, advancements in technology, and the emphasis on high-value care. As a result, patients must navigate a complex system that has developed over time based on outdated rules that constrain innovation and create inefficiencies. This has created unnecessary challenges for healthcare providers to deliver coordinated, high-quality care. Modernizing Medicare statute and regulations to reflect the evolution of care delivery—embracing new care settings, interoperability, and payment models—will be critical to meeting the needs of an aging population and supporting a more effective healthcare system. Doing so is critical to ensure Medicare beneficiaries benefit from the right care at the right time in the right setting.

AMGA recommends reforming Medicare statutes and regulations to promote broader adoption of high-value care, both in value-based care models and traditional Medicare by removing regulations that hinder the operations of group practices and integrated systems without improving access to care or the quality of care.

AMGA recommends Congress:

- **Reform quality measures based on AMGA's Value Measure Set**: Quality measures must prioritize outcomes-focused metrics and reduce unnecessary reporting burdens.
- **Modernize the physician self-referral laws to account for changes in high-value care**: High-value models of care should be exempt from self-referral laws, and providers should have the flexibility to identify the most appropriate post-acute care facilities for their patients.
- **Reform documentation and billing rules**: Current documentation and billing requirements are excessive and often repetitive, creating administrative burden and delays.

- **Reform Medicare Advantage prior authorization to eliminate delays in care**: Prior authorization results in significant delays and administrative burdens and should be eliminated to the extent possible.
- **Reform post-acute care payment silos**: The lack of a unified payment framework for post-acute care inhibits seamless transitions between care settings and creates barriers for providers who are striving to deliver integrated, high-value care.
- **Eliminate the three-day stay requirement for skilled nursing facility (SNF) care**: The requirement for a three-day inpatient hospital stay as a prerequisite for coverage of skilled nursing facility (SNF) care is outdated and unnecessarily restrictive. Eliminating it would reduce hospital congestion, improve care coordination, and lower healthcare costs.
- **Reform Medicare Annual Wellness Visit rules**: Annual Wellness Visits require extensive documentation and data collection and entry, much of which is redundant since it has already been recorded in the patient's record.
- **Eliminate geographic and originating site restrictions for Medicare telehealth coverage**: The geographic and originating site requirements for Medicare telehealth coverage are outdated barriers that hinder access to care.
- **Permanently extend the ability to prescribe controlled medication via telehealth**: Congress should permanently waive the prohibition against the prescribing of controlled substances during a virtual visit.
- **Establish a national licensing framework**: A national licensing framework or an expanded interstate compact would allow physicians and other healthcare providers to practice in multiple states without duplicative licensing processes.

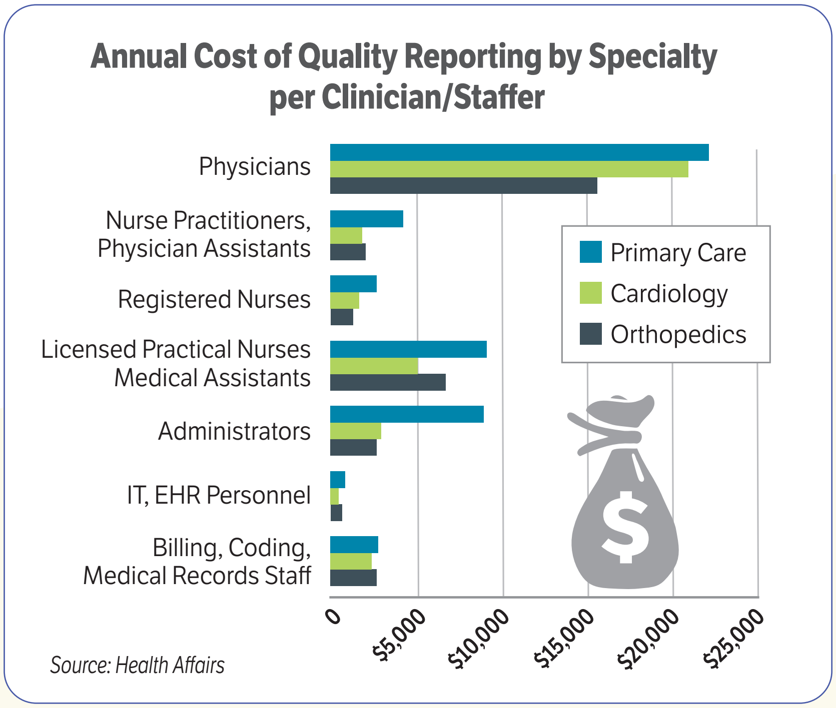
Reform quality measures based on AMGA's Value Measure Set

Quality measurement in the Medicare program plays a critical role in promoting high-value care, improving patient outcomes, and holding providers accountable. Medicare evaluates provider performance across domains, such as patient experience, safety, care coordination, and clinical outcomes. These metrics not only inform payment adjustments and plan ratings, but also help beneficiaries make more informed choices. However, the system faces ongoing challenges, including administrative burden, data lag, and questions about whether current measures truly reflect meaningful improvements in patient care. Improving quality measurement in Medicare requires adopting a streamlined and outcomes-focused approach, such as AMGA's Value Measure Set. This measure set emphasizes outcomes that matter most to patients while minimizing the administrative burden associated with overly complex and redundant reporting requirements. AMGA selected the 14 measures to address the flaws with the current quality measurement and reporting system, which suffers from duplicative measures and a lack of data standardization. AMGA members report hundreds of different quality measures to various public and private payers, the vast majority of which are not useful in evaluating or improving the quality of care provided. There is a significant cost to measure reporting. Research has indicated 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.[1] By prioritizing measures that are evidence-based, actionable, and reflective of population health goals, Congress and CMS will promote high-value care. These changes would help providers focus on delivering high-quality, coordinated care rather than navigating fragmented and duplicative quality reporting systems.

---

1. Casalino LP, Gans D, Weber R, Cea M, Tuchovsky A, Bishop TF, Miranda Y, Frankel BA, Ziehler KB, Wong MM, Evenson TB. US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures. Health Aff (Millwood). 2016 Mar;35(3):401-6. doi: 10.1377/hlthaff.2015.1258. PMID: 26953292.

AMGA is pleased CMS introduced the Universal Foundation measure set as a streamlined framework to align quality reporting across its various programs. This measure set draws inspiration from AMGA's Value Measure Set, which prioritizes outcomes-focused metrics and the reduction of unnecessary reporting burdens. Incorporating AMGA's Value Measure Set into Medicare's quality programs—and eventually Medicaid programs—would help reduce reporting fatigue, promote provider engagement, and drive meaningful improvements in care delivery.



Source: Health Affairs

Modernize the physician self-referral laws to account for changes in high-value care

Physician self-referral laws, such as the Stark Law, were designed to prevent conflicts of interest in fee-for-service environments, but they have become misaligned with the evolving landscape of healthcare delivery. As care shifts toward high-value models emphasizing coordination, efficiency, and outcomes, these regulations often hinder innovative arrangements that incentivize collaboration among providers. Current laws create significant compliance challenges and limit opportunities to share savings or risk in ways that align with high-value care goals. Reform is needed for Accountable Care Organizations (ACOs), bundled payment programs, and other value-focused initiatives to thrive while maintaining safeguards against abuse. By adapting to be consistent with modern care delivery, reforms can promote improved care coordination and better patient outcomes. High-value care models should automatically be exempt from self-referral laws, as the incentives the prohibitions were intended to prevent do not exist in high-value care models.

In addition, providers in high-value care models need the flexibility and ability to identify the most appropriate post-acute care provider and facilities and provide this information to their patients. The use of preferred provider lists for post-acute care referrals can help improve patient outcomes by directing patients to high-quality facilities with proven records of accomplishment. Preferred provider networks are typically selected based on performance metrics—such as readmission rates, patient satisfaction, and adherence to care protocols—ensuring continuity of care and better health outcomes. For providers, these lists also streamline the referral process, reduce administrative burdens, and support alignment with high-value care goals by prioritizing care coordination. Additionally, guiding patients toward high-performing post-acute care providers can help optimize healthcare spending and avoid all of the problems associated with poor-quality care.

Reform documentation and billing rules

Modernizing Medicare's documentation and billing rules is critical to reducing administrative burdens and improving the quality of patient care. Many current rules are rooted in outdated practices and require excessive documentation for compliance purposes rather than for clinical necessity. These rules often lead to redundant tasks, such as providers needing to document the same information in multiple formats, which takes time away from direct patient care. Adopting a streamlined approach, including the use of templates, electronic health records, and artificial intelligence tools, can improve efficiency and reduce errors.

The transition to high-value care requires substantial investments of time and money by healthcare providers. Practices must engage their legal teams to ensure compliance, retrain staff to accommodate new workflows, model financial performance under high-value models, and update IT systems to meet new reporting requirements. These efforts consume valuable time and resources that could otherwise be devoted to patient care. While successful implementation of high-value care can result in better patient outcomes and justify these investments, the administrative burdens should be minimized. Changes to existing models that introduce further burdens should only occur if absolutely necessary. Streamlining regulatory requirements and providing compliance support for providers will encourage participation in voluntary models while helping those in mandatory models focus more time on patient care and less time navigating complex rules.

A prime example of streamlining is the data collection process used to calculate the Composite Quality Score (CQS) in the upcoming Transforming Episode Accountability Model (TEAM). The CQS relies on quality measures already collected through the CMS Hospital Inpatient Quality Reporting (IQR) Program and the Hospital-Acquired Condition (HAC) Reduction Program.[2] By leveraging existing reporting systems rather than creating new requirements, CMS can significantly reduce the compliance burden on providers, encouraging participation and maximizing the time spent on patient care.

Signature Required

Determining which provider is required to sign a face-to-face order is complex and convoluted when an ambulatory provider (as opposed to a provider discharging a patient from an acute care setting such as a hospital or skilled nursing facility) orders home care.

When the face-to-face encounter is completed at a primary or specialty care appointment by a clinician who is not usually part of the patient's care team—such as a covering physician—Medicare regulations require that the provider must also sign the patient's home health plan of care and ongoing orders, as well as continue to follow the patient while they receive home health services. This requirement does not reflect how team-based care is provided.

Conversely, CMS should avoid introducing new requirements into high-value models without fully understanding their impact on clinical workflows. For example, the Increasing Organ Transplant Access (IOTA) Model would mandate that providers notify all patients on transplant waitlist of every instance when an organ was declined on the patient's behalf, along with the reasons for declination.[3] Although well intentioned, such a policy would impose significant administrative burden on smaller transplant programs and cause emotional distress to patients.

In 2017, CMS launched its Electronic Clinical Quality Measure (eCQM) Strategy Project aimed at balancing value and burden based on stakeholder feedback. Each individual CMS quality program determines the number of eCQMs a health system reports. Providers face a number of burdens in the implementation and reporting of eCQMs. Although CMS has worked hard to address some of these issues,[4] consistent burdens remain, such as documentation required for eCQM reporting not directly supporting patient care, multiple submission mechanisms and formats leading to delays and user challenges, and concerns with meaningful connections between certain eCQMs and quality

---

[2] 89 FR 69775

[3] 89 FR 43521

[4] https://pmc.ncbi.nlm.nih.gov/articles/PMC8510288/#sec10

improvement. CMS should continuously evaluate its efforts to remove provider burden to encourage better high-value care participation. In fact, AMGA supports H.R. 483, Health Care Efficiency Through Flexibility Act, which delays the transition of ACOs from reporting quality measures via the CMS Web Interface portal to eCQMs.[5]

Additionally, frequent coding changes present significant challenges for providers. Given the immense financial impact of risk adjustment on high-value care models, changes to coding standards can necessitate reevaluating financial projections and making program adjustments if those projections worsen. Furthermore, clinicians need retraining to align with new standards and ensure appropriate documentation of patient health. Simplifying coding standards and offering comprehensive retraining programs would facilitate a smoother transition to high-value care.

Reform Medicare Advantage prior authorization to eliminate delays in care

CMS recently implemented new timeframes for Medicare Advantage (MA) prior authorizations to enhance transparency and reduce delays in care. As of 2024, plans must make a determination for standard prior authorization requests within seven calendar days, and expedited requests must be addressed within 72 hours. Additionally, plans must provide specific reasons for any denials, improving clarity for both providers and patients.

MA prior authorization rules and timelines often result in significant care delays for patients and administrative burdens for providers. These delays occur as providers wait for approvals for medically necessary services, which can create stress for patients needing timely care. Most prior authorization requests are ultimately approved on appeal, but the process consumes valuable time and resources, detracting from

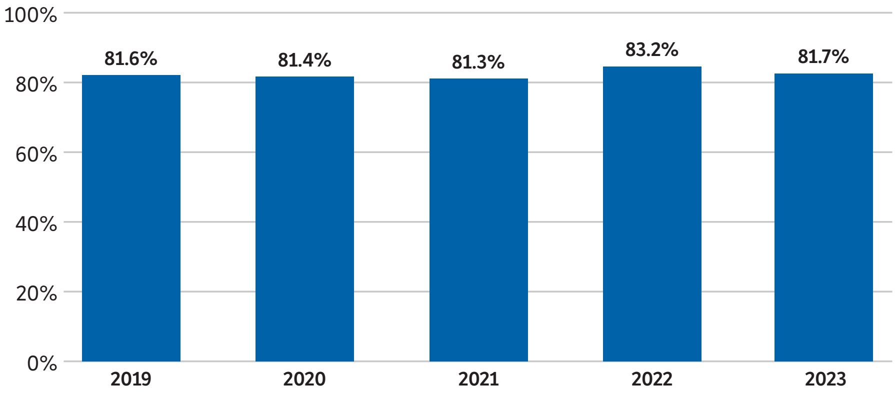
Dr. Scott Hines on Changes to Risk Adjustment

There is significant education that goes into ensuring that risk adjustment coding completely and accurately captures the disease burden of patients. There is also significant investment in systems that reduce the burden of coding accurately and completely. Changing the rules midstream means time and money needs to be spent revamping education and these systems. Beyond lost time and increased investment, revenue that is projected to come from risk coding is being reduced by millions of dollars each year, meaning that there are fewer resources available to reinvest in the ACO to better care for patients.

— **Scott Hines, MD**, *Chief Quality Officer, Crystal Run Healthcare*

More than 80% of Denied Prior Authorization Requests That Appealed Were Overturned

Share of reconsiderations that were fully or partially favorable, 2019–2023



Source: Medicare Limited Data Set, Contract Years 2022 and 2023 Part C and D Reporting Requirements, Public Use File, Part C and D Reporting Requirements Contract Years 2019–2021.

---

[5] https://www.congress.gov/119/bills/hr483/BILLS-119hr483ih.pdf

patient care. The appeals process also highlights inefficiencies, as the high approval rates suggest that many initial denials may be unwarranted. These delays can exacerbate medical conditions, hinder access to critical treatments, and lead to frustration among patients and clinicians alike, underscoring the need for streamlined prior authorization policies. For example, an AMGA member reports instituting a 14-day delay in scheduling magnetic resonance imaging (MRI) simply to manage the denials from payers. While ultimately scheduled, approved, and reimbursed, the system effectively penalizes the patient.

The need for prior authorization is also eliminated as more providers transition to high-value model of care, whether through MA plans or other models. High-value care shifts the focus from the quantity of services provided to the quality and outcomes of patient care, effectively eliminating incentives for unnecessary tests and procedures. Under traditional fee-for-service models, providers are reimbursed based on the number of services performed, which can lead to excessive testing and procedures, some of which may not be medically necessary. However, in a high-value care system, providers are rewarded for improving patient health outcomes, reducing hospital readmissions, and managing chronic conditions effectively. This approach naturally discourages the overutilization of services, thereby reducing the need for prior authorization—a process originally designed to control unnecessary costs. By aligning provider incentives with patient health rather than service volume, high-value care streamlines the approval process, minimizes administrative burdens, and ensures that patients receive only the most appropriate and necessary treatments.

> *"Hospitalized patients routinely wait days for prior authorization to allow them to continue their care at a skilled nursing facility. And if the request isn't back by Friday, the patient ends up staying all weekend at the hospital."*
>
> — **Dan Duncanson, MD**, *CEO, SIMEDHealth, LLC*

Reform post-acute care payment silos

Medicare's payment silos for post-acute care services—such as skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), home health agencies (HHAs), and long-term care hospitals (LTCHs)—create significant administrative burdens. Each type of care operates under distinct payment systems and quality reporting programs, with differing rules, documentation requirements, and reimbursement processes. This fragmentation requires providers to navigate complex regulations, leading to inefficiencies and delays in patient care coordination. The lack of a unified payment framework also inhibits seamless transitions between care settings, creating barriers for providers who are striving to deliver integrated, high-value care. Modernizing these payment systems to promote care coordination across settings would reduce administrative burdens, improve outcomes, and align with Medicare's broader shift toward high-value care delivery.

Eliminate the three-day stay requirement for skilled nursing facility (SNF) care

The rule requiring a three-day inpatient hospital stay as a prerequisite for coverage of SNF care is outdated and unnecessarily restrictive. This policy, established when hospital stays were longer and healthcare delivery was less advanced, no longer reflects the capabilities of modern medicine. Today, many patients can safely transition to SNF care or receive similar support without an extended hospital stay. Eliminating this requirement would reduce hospital congestion, improve care coordination, and lower healthcare costs by allowing clinicians to determine the appropriate level of care based on medical necessity rather than arbitrary length-of-stay criteria. Moreover, doing so aligns with Medicare's broader efforts to promote high-value care, enabling quicker access to post-acute services and better patient outcomes.

ACOs and MA plans benefited from CMS' ability to waive the three-day stay requirement, and they have demonstrated lower hospitalization rates and improved care coordination, emphasizing the benefits of a more flexible, patient-centered approach to SNF utilization. By eliminating the mandatory three-day stay, as was done during the COVID-19 public health emergency (PHE), the waiver supports a more efficient and cost-effective healthcare system while enhancing patient outcomes. The waiver of the Medicare-required three-day hospital stay for SNF coverage has significantly reduced costs and improved patient outcomes by allowing for more direct and efficient transitions to post-acute care.[6] Waiving this requirement enables patients to receive timely rehabilitative care, reduces hospital congestion and overall expenditures, and improves functional recovery as well as reduces readmission rates.

Reform Medicare Annual Wellness Visit rules

The Medicare Annual Wellness Visit (AWV), introduced as part of the Affordable Care Act, is intended to promote preventive care for beneficiaries. However, it has become a source of significant administrative burden for providers. The AWV requires extensive documentation, including the creation of a personalized prevention plan and the review of a detailed health risk assessment. These requirements often demand time-consuming data collection and entry, much of which is redundant, as it has already been recorded in the patient's record. The complexity of compliance detracts from time better allocated to direct patient care. Also, the lack of alignment with other Medicare quality initiatives compounds the inefficiencies. Simplifying the AWV process and integrating it into existing care delivery frameworks would reduce provider burden while maintaining its preventive benefits.

Improving Medicare's Annual Wellness Visits

AMGA recommends Medicare Annual Wellness Visits (AWVs) be expanded to address chronic medical conditions.

Current rules only allow providers to address preventative health during an AWV.

If patients ask about their diabetes, hypertension, chronic obstructive pulmonary disease, or other chronic conditions, either providers are not allowed to address it at that visit or they trigger a copayment for the visit.

To bill for an AWV that included addressing a chronic condition, providers must submit a modifier.

Providers who submit too many modifiers are audited, so providers are afraid to do this.

Under current rules, patients are inconvenienced by having to either make another visit or they are upset because they have a copayment for a "free" Medicare AWV.

Eliminate geographic and originating site restrictions for Medicare telehealth coverage

Telehealth serves as an excellent case study for demonstrating how a supportive policy framework can positively affect patient care through advances in technology. Before the COVID-19 PHE, telehealth utilization was extremely low.

Under traditional Medicare rules, telehealth services generally are covered only if the patient is located at an approved originating site, such as rural health clinics, federally qualified health centers, hospitals, physician offices, or SNFs. Notably, the list of eligible originating sites in the Social Security Act does not include the patient's home,[7] requiring patients to travel to physician offices or clinics to receive care. Prior to the COVID-19 PHE waiver flexibilities, this statutory barrier presented a major care access issue for patients with limited transportation, who would have greatly benefited from provider care via telehealth communication technology. Further, outside of certain Medicare

---

[6] Center for Medicare and Medicaid Innovation, Skilled Nursing Facility 3-Day Waiver: Analysis of Use in ACOs 2014 to 2019. Available at www.cms.gov/priorities/innovation/data-and-reports/2023/snf-waiver-summary

[7] 42 CFR 410.78(b)(3)

demonstration projects, patients were required to receive telehealth services from an eligible “originating site” located in a rural health professional shortage area (HPSA) or a county not included in a Metropolitan Statistical Area.[8] These restrictions aim to target areas with limited access to in-person healthcare services, but exclude many urban or suburban beneficiaries who could also benefit from telehealth.

Further, allowing healthcare providers to conduct telehealth appointments outside of their usual facility offers numerous benefits for both patients and the healthcare system. Providers can offer more flexible scheduling, reducing wait times and improving continuity of care. This flexibility also helps alleviate provider burnout by allowing them to deliver care from a location—including their own homes—that best suits their workflow, ultimately increasing efficiency. Additionally, in times of PHEs or natural disasters, remote telehealth capabilities ensure that patients continue to receive necessary medical attention without overwhelming healthcare facilities.

Why Telehealth?

AMGA Members Respond

"I can see my patients' living conditions and get a better understanding of their life."

"Medication reconciliation is easier when patients have all their prescriptions."

"Video lets my patients administer their meds and make sure they are stored properly."

"I can make sure patients are eating the right foods just by having them show me their fridge."

The geographic and originating site requirements for Medicare telehealth coverage are outdated barriers that hinder access to care, particularly for beneficiaries in underserved and rural areas. These requirements, which limit telehealth services to specific locations such as rural areas and approved healthcare facilities, fail to account for the widespread adoption of telehealth technology and its demonstrated effectiveness in delivering care across settings. Eliminating these restrictions would allow beneficiaries to receive telehealth services while in their homes or other convenient locations, fostering greater equity in access to care. Removing these limitations aligns with the modern realities of healthcare delivery, supports care continuity, and enhances the ability of Medicare to meet the needs of an increasingly tech-savvy patient population. By modernizing telehealth regulations, Medicare can expand access to timely, high-quality care, particularly for those who face mobility, transportation, or geographic barriers.

The waiver of originating site and geographic location requirements during the PHE allowed medical group practices and integrated systems of care to have embedded telehealth in their clinical workflow. Telehealth enhances patient engagement, which is fundamental to the success of high-value care models. Therefore, it is critical for Congress

---

[8] 2 CFR 410.78

to make these flexibilities permanent, such as through the Creating Opportunities Now for Necessary and Effective Care Technologies for Health Act.[9]

Permanently extend the ability to prescribe controlled medication via telehealth

The ability to prescribe controlled medications via telehealth has proven essential in expanding access to care, particularly for patients in rural or underserved areas and those managing chronic conditions, pain, or mental health needs. During the COVID-19 PHE, temporary waivers allowed telehealth prescribing without requiring an in-person evaluation, enabling patients to receive timely and necessary treatments. As virtual healthcare expands, permanently extending this ability to prescribe controlled substances during a virtual visit is critical to ensuring continuity, reducing barriers to care, and addressing provider shortages. Safeguards against misuse can be maintained while leveraging telehealth to meet the growing demand for accessible, patient-centered care. Congress should permanently waive the prohibition against the prescribing of controlled substances during a virtual visit.

> *"The possibility of losing telehealth services already has created chaos in our endocrinology and behavioral health departments."*
>
> — **Paul Pritchard, MD, MBA**, *Vice President and Chief of Quality, Prevea Clinic*

Establish a national licensing framework

As healthcare delivery increasingly incorporates telehealth and mobile technologies, the need for a national physician and provider licensing framework has become more pressing. Current state-by-state licensing requirements create significant barriers for patients requiring continuity of care or specialized expertise from their known and trusted physicians. A national licensing framework or an expanded interstate compact would streamline this process, enabling physicians and other healthcare providers to practice in multiple states without duplicative licensing processes. This reform would enhance access to care and ensure patients have the option of receiving treatment from a care team familiar with their history and individual needs.

A national framework is particularly useful for patients in rural settings or for patients who need to access specialists, which can be a challenge in large parts of the country. By nationalizing the medical license, these patients can access care across state lines via telehealth. This reform also recognizes that many integrated healthcare systems are multi-state. As a result, these systems may have specialists and subspecialists located in an urban setting or near a tertiary care hospital in one state that is unavailable to patients living in neighboring states via telehealth, necessitating a potentially long drive.

Conclusion

Effective collaboration among stakeholders is crucial for overcoming barriers due to outdated Medicare statutes and rules. Providers, payers, policymakers, and patient advocacy groups must work together to identify and address challenges.

Addressing statutory and regulatory barriers will help reduce administrative complexity in the healthcare system and ensure Medicare's promise from the 1960s matches the on-the-ground experience of patients and clinicians today. Modernizing Medicare laws and regulations will improve provider operations and reimbursement structures, which ultimately will improve healthcare delivery and the patient experience. A list of additional barriers are detailed in the table on the next page.

---

[9] https://www.britt.senate.gov/wp-content/uploads/2025/04/connect1.pdf

Regulatory and Legislative Barriers

Barrier	Issue	Citations/Reference Points
Prior Authorization	The prior authorization process leads to delay in patient care and payment reductions due to cumbersome requirements and errors, resulting in payers forgoing payment for appropriate medical services.	42 CFR Chapter IV, Subchapter B: §422.122, §422.568, §422.570, §422.572
Merit-Based Incentive Payment System (MIPS) Low Volume Threshold	Exempting too many providers from the Merit-Based Incentive Payment System (MIPS) undermines the program and minimizes rewards available due to budget neutrality requirements.	42 CFR Chapter IV, Subchapter B §414.1310
Patient-Threshold Requirements for CMS High-Value Care Models	Arbitrary minimum patient numbers eliminate smaller, non-urban practices from participation in CMS high-value care programs.	CMMI models: Request for Application
Telehealth Prescription of Controlled Medication	Expiring flexibilities for telehealth prescriptions of controlled medications will burden patients and providers.	42 CFR Part 12 Chapter II § 1307.41
Excessive Penalties for Information Blocking	ONC's final rule implementing penalties under the 21st Century Cures Act could impose significant fines on providers found to engage in information blocking.	45 CFR Part 171; RIN 0955–AA05; 21st Century Cures Act
Face-to-Face Requirements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	Unclear Medicare rules for durable medical equipment cause administrative burdens and care delays.	42 CFR 410.38(d)(2)
DMEPOS Written Order/ Prescription	Documentation requirements for durable medical equipment orders add unnecessary burdens.	42 CFR 410.38(d)(1)
Home Health Services Timeframe Requirements	Rescheduling visits requires physician permission, creating administrative burdens.	42 CFR 424.22(b)(1)
Skilled Nursing Facility 3-Day Rule	Requirement for a 3-consecutive-day inpatient hospital stay prevents transitions to appropriate care settings.	Section 1861(i) of the Social Security Act and 42 CFR 409.30
Medicare Advantage Surveys	Patients need help understanding surveys, potentially leading to negative penalties for providers.	42 CFR 422.162(a) "CAHPS"
Dual-Special Needs Plans (D-SNP) Education for Providers	Redundant education requirements for providers increase administrative burdens.	42 CFR 422.107(c)
Documenting Suspect Conditions from Home Assessments	Inaccurate "suspect" conditions must be documented, potentially leading to care denials.	42 CFR 424.22(c)(1)
Preferred Provider List	Providing a list of preferred post-acute care facilities can improve patient outcomes and care coordination. This policy should be extended beyond the Next Generation ACO demonstration and apply to all providers in Medicare high-value care arrangements.	Next Generation ACO Demonstration

Support Practices Serving Rural and Underserved Populations in High-Value Care

AMGA Goal

Develop tailored support and incentives for small practices to participate in high-value care initiatives.

In 2021, the Centers for Medicare & Medicaid Services (CMS) announced its vision to have all Medicare beneficiaries in an accountable care relationship by 2030.[1] Under current policy, a lack of participation from small practices will prevent CMS from reaching this goal and, accordingly, prevent the patients served by these practices from experiencing the benefits of high-value care. AMGA recommends tailoring policies for smaller practices, those in rural areas, and those caring for underserved populations to ensure a successful transition to value.

While such practices serve populations well positioned to benefit from high-value care, there are a number of barriers preventing these providers from making the transition to value. In the context of the Medicare Access and CHIP Reauthorization Act (MACRA), small, rural, or underserved practices and individual providers largely have been exempt from the Merit-Based Incentive Payment System (MIPS). We cannot leave behind small and rural practices, as well as those caring for underserved patients in either the fee-for-service system or high-value care models.

To ensure all Medicare beneficiaries benefit from high-value care, CMS must develop tailored support and incentives for such practices to participate in high-value care initiatives rather than exempting them.

AMGA recommends Congress:

- **Create CMS regional hubs for small and underserved practices**: CMS regional hubs can create a networked environment where small practices share best practices, pool resources, and learn to thrive in the evolving healthcare landscape.
- **Scale models and strategies to align with the needs of small practices**: Models need straightforward pathways for small practices to progress toward higher levels of high-value care participation through reduced risk, standardized performance metrics, and predictable timelines.
- **Adopt a phased approach for practices in rural and other underserved areas**: Small and rural participants should be given a ramp-up period during which they are not exposed to downside risk.

Small and underserved practices face unique barriers to participating in high-value care arrangements. Transitioning to high-value care requires significant upfront investments of both money and staff time. Without access to economies of scale, it can be difficult for such providers to make these investments. Unlike larger systems, which can devote entire teams to high-value care, these practices often lack the staff necessary to evaluate high-value care model options. This barrier is magnified for practices serving disadvantaged populations.

---

[1] https://www.cms.gov/priorities/innovation/about/strategic-direction#:~:text=All%20Medicare%20fee%2Dfor%2Dservice,cost%20of%20care%20by%202030.

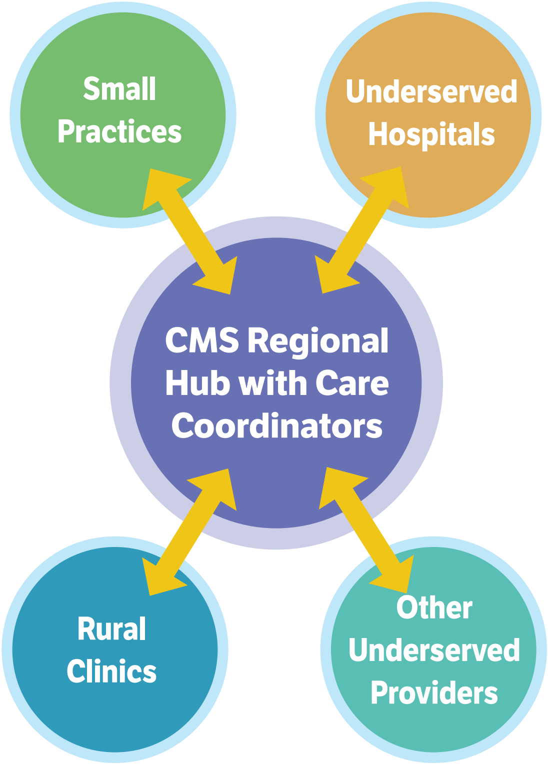
Rural practices face additional challenges. These providers are often the sole source of care for their communities and must provide essential services without having the patient volumes to sustain such services. Existing policies, such as cost-based reimbursement for critical access hospitals (CAHs), account for the unique nature of rural providers, but they make integration with high-value care models more complicated.

Create CMS regional hubs for small and underserved practices

AMGA recommends CMS create, develop, and manage regional hubs. These hubs can play a pivotal role in supporting small medical practices as they navigate high-value care models and fee-for-service programs like MIPS. While some advocate for permanently exempting small practices from MIPS due to their limited resources, doing so would risk depriving these practices and their patients of the benefits of improved care quality and value. Regional hubs can provide tailored support to small practices, helping them adapt to high-value care requirements and meet MIPS performance metrics. Support includes centralized services such as data analytics, care coordination training, and assistance with quality reporting, all designed to minimize administrative burdens and enhance outcomes. Small practices can use these resources to build the skills and infrastructure necessary to succeed in high-value care environments without being excluded from programs designed to promote quality and accountability.

> *"The last few years we've been prevented from participating in the Medicare value models because our number of beneficiaries fell below the arbitrary 5,000 requirement. We haven't been able to get other small practices to join in with us as an ACO, likely because they haven't had to move into any type of value or MIPS process."*
>
> — **Dan Duncanson, MD**, *CEO, SIMEDHealth, LLC*

Smaller practices face structural barriers to implementing high-value care caused by their patients' social drivers of health, such as serving patients in remote geographic locations or with limited access to technology. Encouraging collaboration could help mitigate these barriers by allowing providers to share success stories and improve feedback to CMS on how to better account for these social drivers through their models.



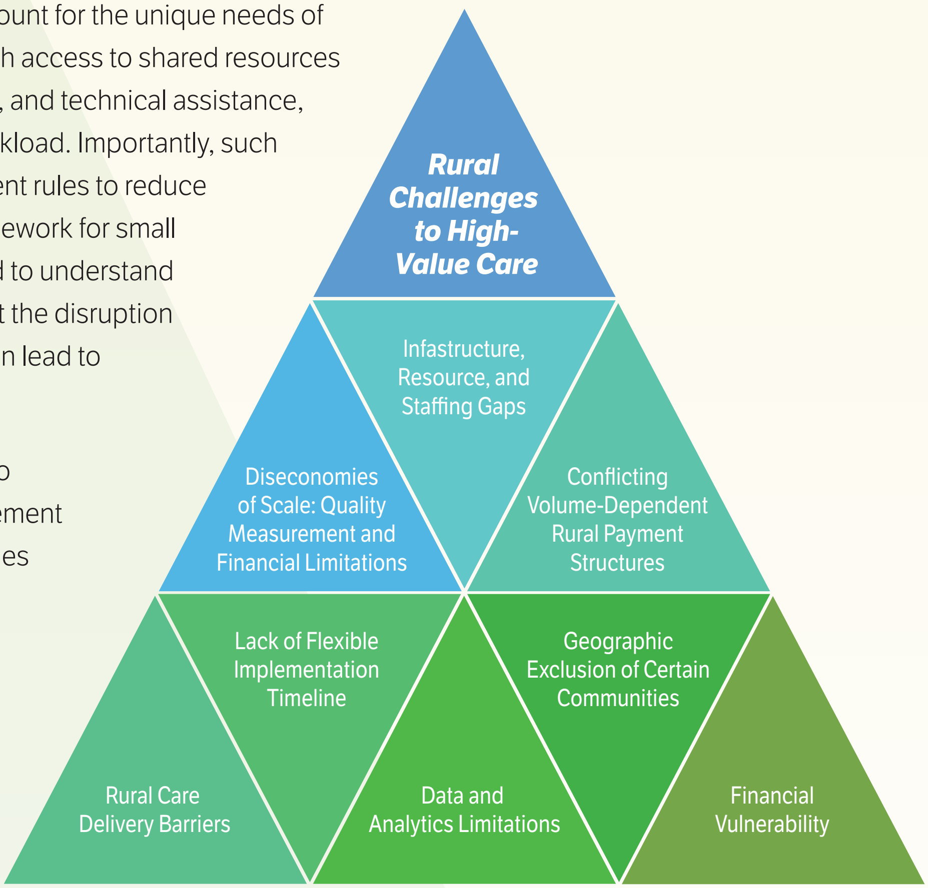
Regional hubs provide tailored support to underserved and rural practices, including centralized services such as data analytics, care coordination training, and assistance with quality reporting.

By fostering collaboration, CMS regional hubs can create a networked environment where small practices share best practices, pool resources, and learn to thrive in the evolving healthcare landscape. This collective support empowers practices to enhance patient care while gaining the experience needed to participate in broader high-value care initiatives. Additionally, ensuring that small practices participate in programs like MIPS encourages them to adopt patient-centered strategies, improving care access and outcomes for their patients. Rather than exempting these practices, CMS and Congress should prioritize investments in regional hubs to provide the tools and knowledge small practices need to deliver high-quality care while holding them accountable to the same standards as larger providers.

Such regional hubs also help address staffing challenges. For example, while a small practice could struggle to find the staff necessary to navigate a new model, multiple practices collaborating through a regional hub could share staff dedicated to high-value care programs.

Scale models and strategies to align with the needs of small practices

Small practices are a critical component of the healthcare system, but many face significant challenges in participating in high-value care models due to limited resources and administrative capacity. Scalable models specifically designed for smaller practices are essential to ensure their successful integration into high-value care initiatives. These models should account for the unique needs of smaller practices, providing them with access to shared resources like care coordination, data analytics, and technical assistance, while maintaining a manageable workload. Importantly, such models must have clear and consistent rules to reduce complexity and provide a stable framework for small practices to succeed. Practices need to understand the expectations and metrics without the disruption of frequent policy changes, which can lead to confusion and inefficiency.



Consistency in model design is key to fostering trust and long-term engagement from such practices. Frequent changes in requirements or benchmarks can discourage participation, as small practices may lack the infrastructure to adapt rapidly. These practices also are more vulnerable to swings in results associated with random variation and chance. Scalable models should establish straightforward pathways for small practices to progress toward higher levels of high-value care participation while aligning with Medicare goals. For example, shared-savings models with reduced risk, standardized performance metrics, and predictable timelines can encourage small practices to adopt high-value care strategies. By designing these models to scale according to practice size and capacity, CMS and Congress can promote widespread participation in high-value care, ensuring that all patients, regardless of where they receive care, benefit from improved quality and efficiency.

Adopt a phased approach for practices in rural and underserved areas

All practices, regardless of size or location, should be provided with the necessary support and resources to participate in high-value care. For small practices, this includes a phased approach that allows providers to ease into value without taking on overwhelming risk. Small and rural participants should be given a ramp-up period during which they are not exposed to downside risk. An example of this is the Transforming Episode Accountability Model (TEAM), which offers all participants the option to participate in an upside-only track in year one of the model. In response to comments from numerous stakeholders including AMGA, CMS will also allow safety-net providers to remain in this downside-risk-free track for three years. This will allow these hospitals time to understand the model and high-value care in general before taking on the risk associated with TEAM.

A successful transition to high-value care requires opportunities for all providers to participate in value-based programs. However, many current models impose minimum size or volume requirements that exclude smaller practices. For example, the MIPS low volume threshold excludes providers who do not meet specific thresholds for Part B allowed charges, patients seen, or number of services provided.[2] While eligible clinicians may opt-in to MIPS if they meet at least one criterion, many are exempt from participation. For 2025, CMS estimates that 129,806 clinicians will be prevented from participating in MIPS due to this threshold.[3]

While these thresholds are intended to protect smaller practices from the challenges of complex programs, there are better options than exclusion. Targeted assistance, reduced administrative burdens, or mitigated risk for smaller providers can help them succeed in high-value care programs. As previously noted, TEAM offers "vulnerable" participants serving safety-net populations protection from downside risk during the first three years of the model,[4] allowing a more manageable transition. By contrast, small practices excluded from MIPS will not advance and learn to deliver care under more modern models if they are never expected to participate.

High-value care models should not exclude providers simply because of their size or risk. Instead, policymakers should support CMS in developing solutions that enable these providers to thrive within the value-based framework.

This easing into risk is especially critical given the lack of data around how small practices perform in high-value care models. One of the stated reasons for implementing TEAM was to "better understand the

Case Study:

Building Toward Risk

"We were a small-sized ACO, and a new entry into high-value care when we became a 2012 MSSP. Through our 6 years in the MSSP program, we created savings for Medicare in 4 of the 6 years, but only crossed the sharing threshold in our last year. Despite the very delayed return on our investment of resources into the MSSP, we improved quality and risk adjustment scores year-over-year and saw significant gains in total costs of care versus our peers. These adjustments in our approach to care resulted in terrific ROIs for our high-value care efforts with MA plan and commercial payer arrangements. Had we never started down the MSSP path, it is doubtful we would have put in the effort necessary to create these behavior changes."

— **Dan Duncanson, MD**, *CEO, SIMEDHealth, LLC*

---

2. https://qpp.cms.gov/mips/how-eligibility-is-determined
3. 89 FR 62189
4. 89 FR 69661

impact of a model on a broader range of hospital types, beneficiaries, and communities that are not usually included in a voluntary model." Small practices and hospitals play a critical role in providing care to their communities and should not be exposed to high levels of risk until its impact is better understood.

Another way to help small practices transition to value is to help them cover the upfront costs of this transition. For example, Medicare Shared Savings Program (MSSP) Advanced Investment Payments (AIP) provides advanced payments to providers to help them cover the costs of building the infrastructure necessary to form accountable care organizations (ACOs).

Conclusion

The healthcare system is not on track to fulfill CMS' vision of all Medicare beneficiaries being involved in an accountable care relationship by 2030. To meet this goal, policymakers must remove barriers preventing all practices and hospitals from participating in high-value care. Doing so will bring considerable benefits to the vulnerable populations served by these providers, who are well-suited to benefit from high-value care. For example, rural populations face higher rates of a number of chronic diseases, including diabetes and heart disease,[5] and are more likely to die from cancer than their urban counterparts. By incentivizing proactive treatment, high-value care would help rural patients better avoid or manage these diseases. Providers at small practices also regularly utilize the skills necessary to succeed in high-value care models, which emphasize accomplishing better health outcomes with fewer resources and building relationships with patients. By creating a supportive policy framework, Congress and CMS can empower these providers to benefit from high-value care while serving their communities.

---

5. Coughlin SS, Clary C, Johnson JA, Berman A, Heboyan V, Benevides T, Moore J, George V. Continuing Challenges in Rural Health in the United States. J Environ Health Sci. 2019;5(2):90-92. Epub 2019 Dec 16. PMID: 32104722; PMCID: PMC7043306.

Ensure the Long-Term Sustainability of High-Value Care

AMGA Goal

Increase support and participation in high-value care by ensuring adequate Medicare reimbursement that considers the total and ongoing costs of providing care.

In 2021, CMS set an ambitious goal to have all Medicare beneficiaries in an accountable care relationship by 2030.[1] AMGA applauds this goal, but recognizes that the transition will only be successful if supported by a predictable, stable, Medicare reimbursement system that enables clinicians to meet the needs of an aging population.

The current Medicare Part B reimbursement system plays a crucial role in supporting patient access, but fails to adequately account for rising operational costs. Without an inflation-adjusted payment system, providers face mounting financial pressure, which threatens access to care, quality, and long-term sustainability. Just as other essential sectors adjust for inflation, Medicare Part B reimbursement must reflect the real costs of labor, technology, and medical supplies to avoid potential service reductions or closures.

In addition, evaluating Medicare Part B costs without considering downstream savings in Medicare Part A spending presents a narrow and fragmented view of healthcare expenses. Investments in outpatient and preventative services can offset costly hospitalizations; however, current policy does not fully account for this dynamic.

Finally, for high-value care models to succeed, providers need regulatory stability throughout the program agreement period to effectively plan and implement strategies to improve patient outcomes while managing costs. Frequent changes to program rules or payment methodologies create uncertainty and undermine long-term investments in care coordination, technology, and preventive services.

Why High-Value Care?

High-value care rewards providers based on patient health outcomes rather than the volume of services delivered and promotes team-based care, an approach that is well-suited to address health inequities and manage chronic conditions.

Given that nonmedical factors are estimated to account for 80% of a population's health and that approximately 94.9% of Americans aged 60 or older have at least one chronic condition, the ability of high-value care to incentivize better outcomes in addressing health inequities and chronic conditions will be crucial in controlling long-term healthcare costs.

With the U.S. population rapidly aging—every baby boomer will be eligible for Medicare by 2030—and healthcare workforce shortages are expected to persist into the 2030s, controlling these costs will be essential in maintaining access to high-quality care for elderly Americans.

---

[1] https://www.cms.gov/priorities/innovation/about/strategic-direction#:~:text=All%20Medicare%20fee%2Dfor%2Dservice,cost%20of%20care%20by%202030.

To support clinicians under traditional fee-for-service Medicare and facilitate the shift to high-value care, AMGA recommends that Congress:

- **Establish a baseline inflationary adjustment based on the Medicare Economic Index (MEI) as part of the annual Medicare Physician Fee Schedule (MPFS) reimbursement update**: The gap between clinician reimbursement and the cost of providing care has continued to grow. This must be addressed by including an inflationary update in the MPFS, as similarly recommended by the Medicare Payment Advisory Commission (MedPAC).[2]
- **Increase or eliminate the MPFS budget neutrality threshold**: Budget neutrality requirements, including the spending cap on new services, should be updated to reduce disproportionate impacts on providers; or eliminate this requirement to better align the Part B reimbursement system with the other components of Medicare.
- **Eliminate exclusions from the Merit-Based Incentive Payment System (MIPS)**: The low-volume threshold undermines the program's ability to drive quality and value.
- **Ensure model stability in high-value care arrangements**: Avoid mid-contract changes to model terms that deter provider participation in risk-based models.
- **Recognize Part A savings in Part B reimbursement decisions**: Congress should consider the full picture of Medicare costs and savings when evaluating outpatient services.

What is included in Medicare Part B?

Medicare Part B covers medically necessary and preventive services, including physician office visits, outpatient care, lab tests, durable medical equipment, and some home health services.

Part B also pays for services like chemotherapy, dialysis, and mental health care.

Medicare Part B does not cover physician compensation itself—rather, it reimburses for services rendered based on the MPFS, which determines payment rates for covered procedures and visits.

Establish a baseline inflationary adjustment based on the Medicare Economic Index (MEI) as part of the annual Medicare Physician Fee Schedule (MPFS) reimbursement update

The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) was intended to establish a predictable and supportive framework to help providers transition to high-value care. Central to this framework were up-front incentives and stable financing, particularly through participation in Advanced Alternative Payment Models (APMs). However, MACRA was not designed to account for unforeseen disruptions like the COVID-19 public health emergency (PHE), which delayed many providers' transitions to value. Despite these delays, the time-limited bonuses designed to encourage participation in APMs have not been extended to reflect this enormous setback. Instead, Congress has enacted a series of short-term legislative fixes to prevent Medicare reimbursement cuts, offering temporary relief but little long-term stability.

Critically, MACRA fails to link clinician payment to inflation. Unlike other components of Medicare, Part B lacks an automatic update tied to broader inflation metrics, such as the Consumer Price Index (CPI) or Producer Price Index (PPI). This disconnect leads to reimbursement rates that have not kept pace with real-world costs of medical supplies,

---

2. March 2025 Report to the Congress: Medicare Payment Policy, MedPAC March 13, 2025

technology, and staff salaries—all resulting in financial strain on ambulatory providers. Congressional interventions, while helpful, have done little to close the widening gap between clinician payments and the total cost of providing care.

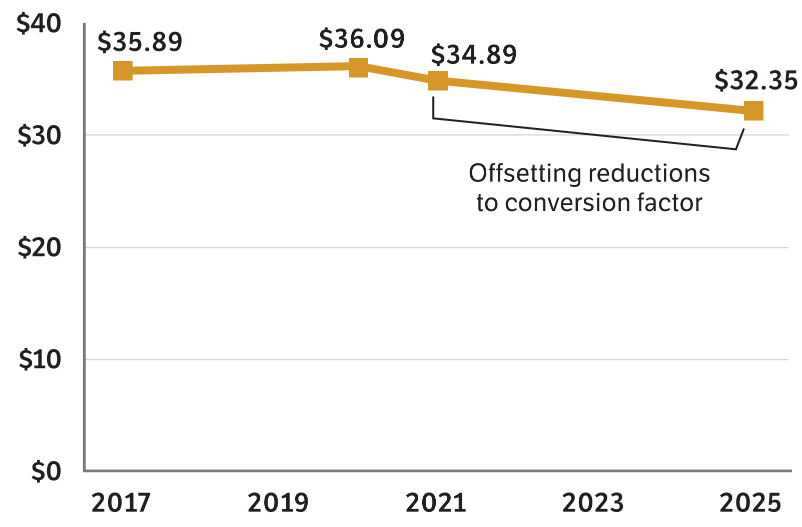
For example, the Consolidated Appropriations Act of 2024 (CAA, 2024) provided partial relief for the 2024 MPFS, but was not enacted until March. This delay caused Part B providers to absorb lower reimbursements for the first quarter of 2024. Even when Congressional relief arrived, the 2024 conversion factor decreased 1.77% from the previous year. This is part of a broader downward trend since MACRA went into effect in 2015, with an overall decrease from $35.75 in 2015 to $32.34 in 2025 (Figure 1). Over the same period, the cost of operating a medical practice has increased by roughly 20%.[3]

This chronic lack of investment in ambulatory clinician services deprioritizes one of the most cost-effective ways to improve Medicare beneficiaries' health. Regular office visits, chronic disease management, and preventative care can help patients avoid costly hospitalizations and complications, yet the payment system does not reflect or reward this value.

> *"Budget forecasts for investments in the technology, personnel, and infrastructure necessary to build and sustain an accountable care organization (ACO) are done so on a multiyear timeframe. Part of that budgeting includes the projected revenue return from those investments in the form of shared savings or premium dollars. Uncertainty over the Medicare conversion factor and other payment mechanisms leads to reluctance to make these investments in the transition from fee-for-service to high-value care."*
>
> — **Dr. Alka Atal-Barrio, MD, FAAP, MMM**, *National Senior Medical Director, Optum Health and Optum West*

Looking ahead, the gap between clinician reimbursement and the cost of providing care is projected to widen. The Centers for Medicare & Medicaid Services (CMS) estimates the MEI will increase by an average of 2.3% annually from 2025 to 2033 (Figure 2).[4] However, under existing legislation, clinician reimbursement remained flat in 2025, and will only rise by 0.75% per year for Advanced APM participants and 0.25% for all other clinicians in 2026 and beyond. This represents a sharp downturn from the modest bonuses (between 5% and

Figure 1. Conversion Factor Reduction 2017–2025



---

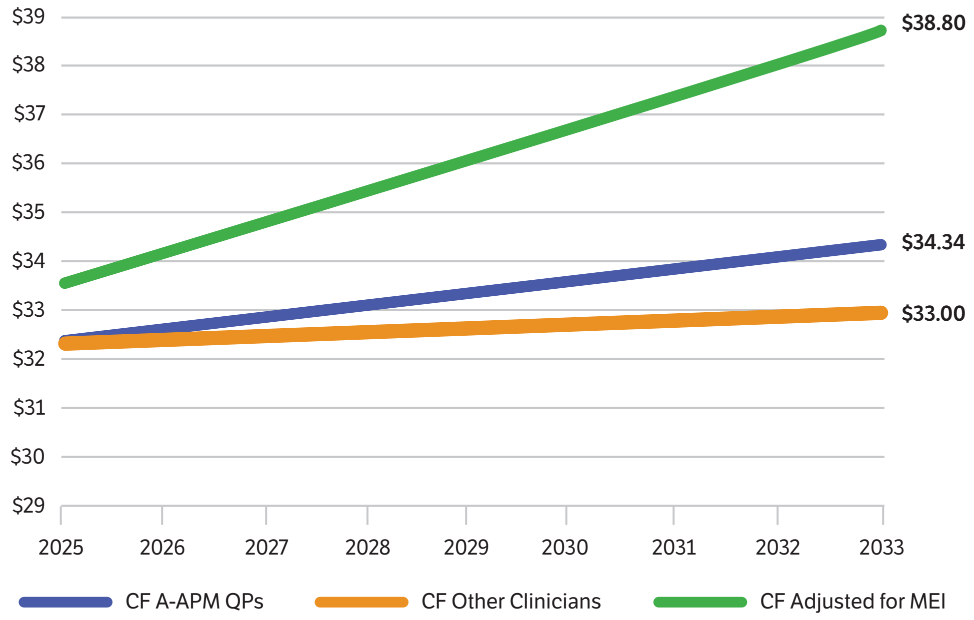
[3] Source: Market Basket Update from 2016 – 2024 Actual Regulation Market Basket Update

[4] https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_Ch1_MedPAC_Report_To_Congress_SEC.pdf

1.88% annually), that Congress created for Advanced APMs from 2017 to 2024.

Without meaningful reform, the trajectory of Medicare reimbursement for Part B providers will continue to erode participation, strain practice sustainability, and undermine the shift to high-value care.

Figure 2. Conversion Factor Updates Under MACRA 2025+ Compared to CMS MEI Projections



Increase or eliminate the MPFS budget neutrality threshold

The Medicare Part B reimbursement system is constrained by outdated budget neutrality requirements, which mandate offsetting reductions to clinician payments if any policy change increases projected spending by more than $20 million in a given year. This threshold, set in 1992, has never been adjusted for inflation or changes in the scope of Medicare services.[5]

While originally intended to control spending, budget neutrality often creates unintended consequences that disproportionately affect providers. When new services, such as advanced diagnostic tools or telehealth options, are added or updated, payment reductions are applied across all services—regardless of their actual cost or value. This results in an inequitable system in which certain providers, especially those offering primary or preventive care, face significant financial strain. These across-the-board reductions often hit primary and preventive care providers the hardest, creating disincentives to offer essential but lower-margin services.

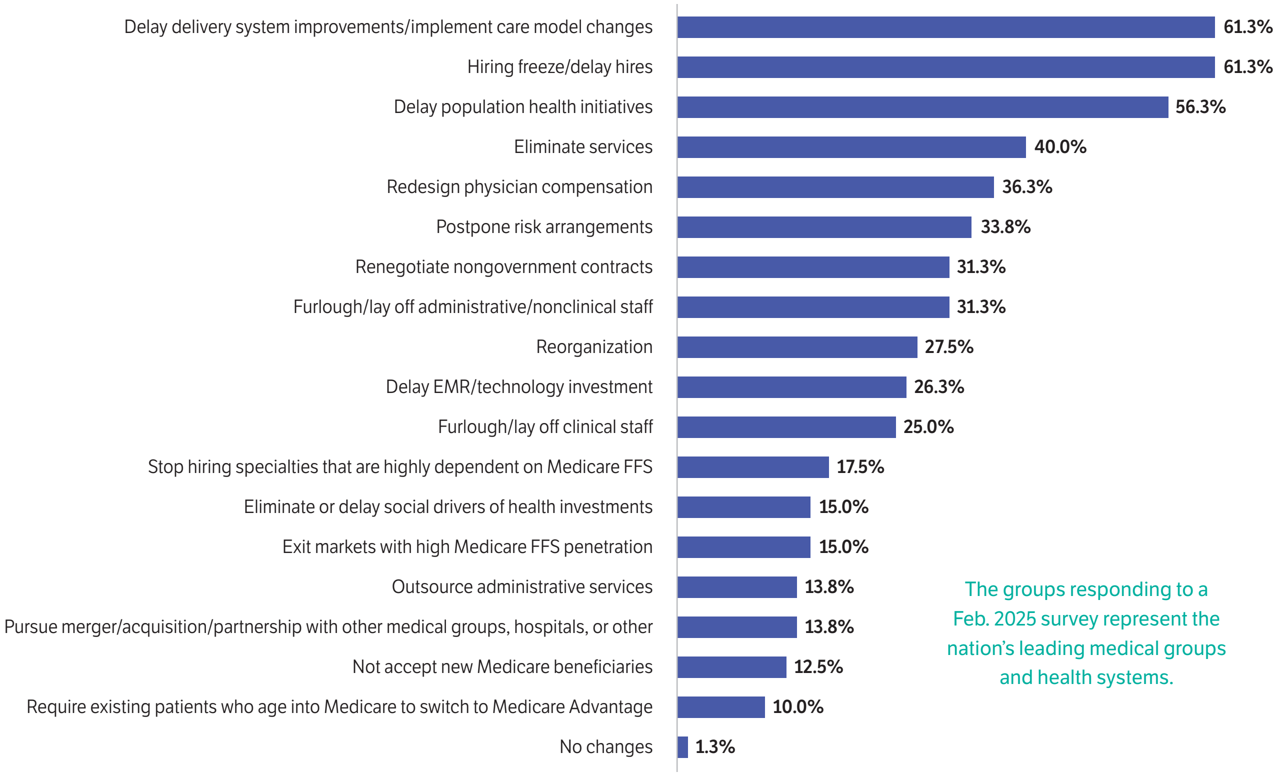
> *"Preventative health is best provided by medical professionals outside of hospitals and the emergency room. Despite this, independent practitioners are being forced to close because of reimbursement cuts and inflating practice expenses."*
>
> — **Scott Barlow**, *CEO, Revere Health*

These policies have had significant impacts on AMGA members and their patients. In a recent survey conducted after the January 2025 conversion factor cut, 40% of respondents reported eliminating services to Medicare patients. Another 25% of respondents furloughed or laid off clinical staff, and 31% furloughed or laid off nonclinical staff. Thirteen percent of survey respondents reported they are no longer accepting new Medicare patients in 2025 (Figure 3). If current trends continue, access and workforce challenges will only worsen.

---

[5] https://bucshon.house.gov/news/documentsingle.aspx?DocumentID=4467

Figure 3. AMGA Survey on Actions Taken Due to 2025 MPFS Conversion Factor Decrease



The groups responding to a Feb. 2025 survey represent the nation's leading medical groups and health systems.

Eliminate exclusions from MIPS

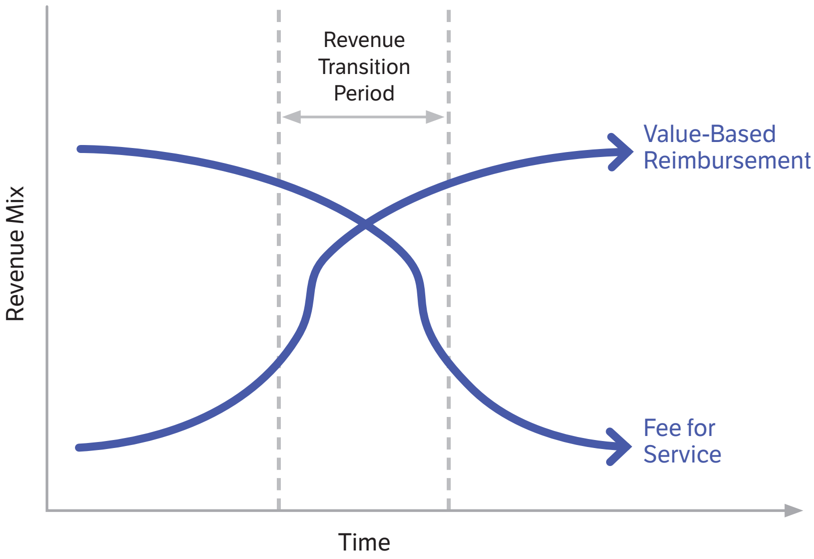
AMGA has long raised concerns that the Merit-Based Incentive Payment System (MIPS) is undercut by overly broad exemptions, especially the low-volume threshold, which precludes a significant number of clinicians from participation. These exclusions undermine the program's goals of improving quality and prevents high-performing providers from receiving meaningful payment adjustments. As detailed in Chapter 5, "Support Practices Serving Rural and Underserved Populations in High-Value Care," AMGA supports policies that ensure all providers engage in performance measurement and reporting. This would create a more comprehensive and equitable system for evaluating and improving care. Rather than broad exclusions, CMS should offer resources and tailored support, such as technical assistance and scalable models, as well as performance feedback tailored to small practices and low-volume providers. Simply put, exempting providers from MIPS undermines the integrity of MACRA and the broader transition to high-value care.

Ensure model stability in high-value care arrangements

Achieving the long-term benefits of high-value care requires providers make upfront investments in staffing, care redesign, infrastructure, and cultural transformation within the practice. These changes demand both time and financial resources, which for most providers requires a predictable operating environment. To successfully transition to value, providers must allocate time to understanding value-based programs, forecast performance, implement the necessary initiatives for participation, and transition to team-based care models. This requires a shift in provider mindset and behaviors to prioritize patient-centered care and coordinated treatment plans. In addition, holding providers accountable for the quality and cost of beneficiary care demands financial risk, which requires payment stability. Even in one-sided or upside-only models, upfront investments can be significant. Given the instability of the Part B reimbursement environment, providers lack both stable financing and the capital needed to make the transition to high-value care.

As high-value care represents a fundamental transformation away from the traditional fee-for-service system, providers must be given adequate financial stability to support the transition. This should include a phased revenue transition period (Figure 4).[6]

Figure 4. Proposed Revenue Transition Period from FFS to High-Value Care



Mid-agreement changes to model rules are a major source of contention, especially those impacting financial elements such as risk adjustment. These changes have historically disrupted provider confidence in high-value care and discouraged participation. Unlike mandatory models, voluntary models do not allow participants to provide feedback on mid-model changes through notice and comment periods.

For instance, the recent change in coding methodology for the MSSP from the 2020 CMS-Hierarchical Condition Category (HCC) model to the updated 2024 CMS-HCC model has required Accountable Care Organizations (ACOs) to revise their coding guidelines, retrain staff to ensure compliance, and adjust their financial forecasts. Similarly, in December 2017, CMS introduced a new risk adjustment factor in the Next Generation ACO Model, which reduced the average risk score by 4.82%, making it significantly harder for providers to achieve profitability under the program. Although the change was announced on December 7, 2017, it was retroactive to payments for the entire year, significantly impairing providers' ability to achieve shared savings.

Similarly, the implementation of new mandatory models must allow providers sufficient time to prepare. Transitioning from fee-for-service to an accountable care model requires operational changes within individual practices and across the broader care continuum. For example, CMS' recently finalized Transforming Episode Accountability Model (TEAM) holds hospitals accountable for most medical spending following select surgical procedures, including services outside of the hospital's direct control, such as post-acute care or physical therapy.

To succeed under TEAM, participants will need time to accurately forecast the costs incurred at their own facilities and at partner facilities and provider groups. This may involve negotiating new or updated agreements and establishing

---

[6] Graph taken from https://www.healthcatalyst.com/learn/insights/hospital-transitioning-fee-for-service-value-based-reimbursements

new care coordination protocols with these partners. CMS has allotted 17 months of pre-implementation preparation time, followed by a 12-month performance period without downside financial risk.[7] While AMGA has significant concerns about the feasibility of generating savings under TEAM, we appreciate the extended runway, which is essential for enabling providers to adapt their operations, build collaborative networks, and effectively manage episode-based care.

Recognize Part A savings in Part B reimbursement decisions

Underfunding Medicare Part B services to control short-term spending overlooks the long-term cost-savings achievable under Part A through innovations in care delivery. Since the COVID-19 PHE, tools like remote patient monitoring and telehealth visits have grown exponentially, enhancing access to care for patients (particularly in rural or underserved areas) and helping them prevent avoidable complications. Modest investments in preventive and outpatient care can result in significant savings by reducing hospital admissions, readmissions, and extended inpatient care covered by Part A.

However, Medicare's current reimbursement policies do not recognize these downstream benefits. To address this, CMS should adopt an integrated approach that aligns financial incentives across Parts A and B. This includes considering projected Part A savings when setting Part B payment rates and encouraging a shift toward high-value care models that reward prevention and early intervention. This approach would not only reduce overall program costs, but also improve patient outcomes by fostering proactive, rather than reactive, care delivery.

Conclusion

Transitioning the American healthcare system to high-value care is crucial for maintaining access to high-quality care and improving health outcomes for Americans. High-value care incentivizes preventative care and enhances coordination across a patient's care team—key strategies for managing chronic conditions and avoiding costly interventions. As the U.S. population ages and widespread healthcare workforce shortages persist, maximizing the efficiency and effectiveness of healthcare delivery through high-value care is increasingly urgent.

For providers to lead this transition, they must have the ability to fund upfront investments. This requires a reliable fee-for-service foundation and assurance that high-value care program rules will not change during the agreement period. Key policy changes—such as linking clinician payment to the MEI, extending Advanced APM bonuses, and ensuring that providers have sufficient time to adapt to new model rules—would create an optimal environment for the high-value care transition. This stability will help prepare the American healthcare system to address the demographic and financial challenges ahead.

Absent these reforms, it will be increasingly difficult for providers—especially those in smaller and under-resourced practices—to bear the risks or costs of transformation. Instead of advancing toward value, they may be forced to freeze hiring, reduce staff, cut population health initiatives, scale back investments in certain programs, or limit services for Medicare beneficiaries. Recognizing the gravity of these consequences, Congress must act to modernize the Medicare physician payment system to support providers in the transition to high-value care.

---

[7] 36 months for participants that qualify as "safety-net" under TEAM.

AMGA MACRA and Value-Based Care Task Force

Chair: Scott Hines, MD, *Chief Quality Officer, Crystal Run Healthcare*

Alka Atal-Barrio, MD, FAAP, MMM, *Chief Medical Officer, Optum WA*

Beth Averbeck, MD, FACP, *Senior Medical Director, Primary Care, HealthPartners Care Group*

Scott Barlow, MBA, *Chief Executive Officer, Revere Health*

Richard Bone, MD, *Senior Medical Director of Population Health, Advocate Medical Group*

Daniel M. Duncanson, MD, CPE, *Chief Executive Officer, SIMEDHealth, LLC*

Paul Pritchard, MD, *Senior Vice President and Chief Medical Officer, Prevea Health*

Elizabeth M. Stambaugh, MD, MMM, *Chief Medical Officer, Wake Forest Health Network, Atrium Health Wake Forest Baptist*

Christina Taylor, MD, *Chief Medical Officer, Clover Health*

Ex Officio: Jerry Penso, MD, MBA, *President and Chief Executive Officer, AMGA*

AMGA Staff Director: Darryl M. Drevna, MA, *Senior Director, Regulatory Affairs, AMGA*

Acknowledgments

The Task Force is grateful for the support of ***Applied Policy****—including Jim Scott, Dr. William Rogers, Meghan Basler, Simay Okyay McNutt, and Hugh O'Connor.*

For more information on the AMGA MACRA and Value-Based Care Task Force Recommendations, contact **PublicPolicyStaff@amga.org**.

AMGA™

One Prince Street
Alexandria, VA 22314-3318

amga.org