AMGA
Advancing High Performance Health

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April 8, 2024

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Chuck Schumer
Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

The Honorable Mitch McConnell
Minority Leader
U.S. Senate
Washington, DC 20510

Dear Speaker Johnson, Leader Schumer, Minority Leader Jeffries, and Minority Leader McConnell:

On behalf of AMGA and our members, I appreciate the opportunity to detail critical healthcare issues that Congress needs to address. Founded in 1950, AMGA represents more than 440 multispecialty medical groups and integrated delivery systems, representing about 175,000 physicians who care for one in three Americans. Our member medical groups work diligently to provide high-quality, cost-effective, patient-centered medical care. Congress must ensure that the necessary infrastructure is in place so AMGA members can continue to provide the highest quality care to their patients.

We appreciate your efforts in March to provide partial relief to providers regarding Medicare Part B reimbursement and an extension of a value-based program incentive. As you continue in the second session of the 118th Congress, we offer the following recommendations on several key issues impacting multispecialty medical groups and integrated systems of care and the communities they serve:

- Sustain Medicare by Preventing Further Payment Cuts
    - Medicare Part B Conversion Factor
    - PAYGO
- Improve and Incentivize Value-Based Models of Care
- Promote Telehealth
- Preserve Medicare Advantage
- Ensure Provider Access to Administrative Claims Data
- Improve Care for the Chronically Ill

Sustain Medicare by Preventing Further Payment Cuts
Over the past few years, decreasing reimbursement rates, coupled with increased labor and supply chain costs, make providing quality care increasingly difficult year after year. A more sustainable reimbursement system must be created so that providers are not subject to similar cuts during this critical time and medical groups can continue caring for their communities. These reductions stem from the following:

Changes to the Medicare Conversion Factor

Providers have faced almost 8% in cuts to Medicare Part B reimbursement over the past four years. Congress continues to pass partial, temporary patches to the Medicare Part B conversion factor, which converts relative value units into an actual dollar amount. Medicare updates the conversion factor annually according to a formula specified by statute and, importantly, within the constraints of Medicare's budget-neutral financing system. However, in 2025, providers expect a larger conversion factor cut than last year, even with past partial relief provided by Congress.

Last year, AMGA surveyed its membership on what actions they would be forced to take if these Medicare Part B cuts were implemented. They also were asked about what actions they took in 2023 in reaction to those Medicare cuts. Twenty-four percent of AMGA respondents either furloughed or laid off employees in 2023. Forty-nine percent of respondents said they will be forced to furlough or lay off employees in 2024 if the cuts continue. Additionally, 44% of these provider groups eliminated services to Medicare patients in 2023, and 65% expect to continue doing so in 2024. Twenty-one percent of respondents instituted delays in social determinants of health investments, and 57% are expected to continue these delays in 2024.[i] It is clear that continued Part B payment reductions will impact Medicare patients' access to care.

Medicare PAYGO Cuts

The American Rescue Plan Act (ARP) of 2021 increased spending without offsets to other federal programs. Under statutory Pay-As-You-Go (PAYGO) rules, any increases to the federal deficit automatically trigger an additional series of across-the-board deductions to federal programs. According to the Congressional Budget Office (CBO), ARP triggered PAYGO, creating a 4% cut or $36 billion in cuts to the Medicare program annually, which significantly impacts the ability of medical groups and health systems to deliver care to the patients in their communities.[ii] Congress delayed these PAYGO cuts the last three years, but by Dec. 31, 2024, policymakers must once again address this issue to ensure that providers' Medicare reimbursements are not cut substantially.

Given the actual and potential impacts continued Medicare cuts will have on providers and their patients, Congress must act to prevent these proposed cuts.

Improve and Incentivize Value-Based Models of Care

Recently, the Centers for Medicare & Medicaid Services (CMS) announced that the Medicare Shared Savings Program (MSSP) had saved the Medicare program $1.8 billion in 2022 compared to spending targets. This marked the sixth consecutive year the MSSP has generated overall savings compared to expected Medicare expenditures. It represents the second-highest annual savings accrued for Medicare since its inception over 10 years ago. About 63% of participating Accountable Care Organizations (ACOs) earned shared savings payments for their performance in 2022.[iii]

The success of the MSSP demonstrates the importance of the 5% Advanced Alternative Payment Model (APM) incentive payment. When the Medicare Access to CHIP Reauthorization Act of 2015 was enacted, it set in motion a transition to value-based Medicare physician payment. Part of the law created a 5% Advanced APM incentive, which motivated providers to move toward value-based payment. Congress temporarily extended the eligibility to earn incentive payments, which will expire at the end of 2024.

The Value Act (H.R. 5013/S. 3503) reinforces the shift to value-based care by extending the 5% Advanced APM incentive payments for an additional two years. This legislative proposal also

strengthens the MSSP by updating it to recognize and reward ACOs. Specifically, the bill eliminates the artificial distinction between high- and low-revenue ACOs, revises benchmark development and shared savings policies, and mandates more technical assistance from the federal government. This legislation also establishes a voluntary ACO track to enable participants to take on higher levels of risk. Congress must extend this incentive payment program and implement reforms to the ACO program by approving the Value Act.

Promote Telehealth

AMGA members have made significant investments in telehealth modalities and platforms, and their patients have come to expect telehealth services as the new normal. Through the Consolidated Appropriations Act of 2023, Congress waived Medicare's telehealth originating site and geographic limitations for an additional two years through Dec. 31, 2024. The law also extended recognition of audio-only payments in that same period. However, these policies should be extended permanently to ensure greater patient access to care. Also, policymakers need to recognize the impact of telehealth reimbursement policies on patient access to quality care. Payment parity between in-office, telehealth, and audio-only should continue permanently, as AMGA members have made significant investments in telehealth modalities and platforms to ensure patients have access to care. Congress should consider the inclusion of the waivers in a comprehensive telehealth legislative package that includes permanent waivers for the expiring provisions as well as the continuation of payment parity between in-office, telehealth, and audio-only to ensure greater patient access to care.

In addition, Congress must address the issue that requires providers to include their home addresses on Medicare enrollment and claims forms beginning Jan. 1, 2025. This provision was not required during the Public Health Emergency, and the requirement was delayed in the CY2024 Physician Fee Schedule. Clearly, making these addresses public will lead to significant privacy and safety concerns for providers, and we urge Congress to repeal this requirement.

AMGA members collaboratively provide care and need a standardized federal licensing and credentialing system for telehealth. This would ensure that the most suitable care team member can provide or suggest the most appropriate care to a patient, regardless of the state in which a provider or patient resides. Policymakers should establish a nationally standardized licensing and credentialing system for telehealth so patients can access care where quality, value, and cost are the main drivers.

Preserve Medicare Advantage

Today, over half of all Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans.[iv] As a financing model emphasizing preventative care and value, MA aligns with the goals of both multispecialty medical groups and integrated systems of care, resulting in improved care at a reduced cost. According to recent data, 54% of MA beneficiaries identify as racial and ethnic minorities. MA plans also have a higher concentration of low- and modest-income patients.[v]

Last year, CMS released an Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for MA Capitation Rates and Part C and Part D Payment Policies, outlining changes to the program's risk-adjustment model. At the time, AMGA recommended against changing the Hierarchical Condition Categories (CMS-HCC) model. AMGA believes that removing codes from the HCC model would not address discretionary coding variation, but rather would remove distinct clinical differences from the model. Additionally, the removal of codes from the HCC model would have a significant impact on providers' financial stability and enrollee access to services.[vi] For example, under the proposed CY 2025 Advance Notice, if CMS finalizes proposed changes to the effective growth rate, risk model revisions,

fee-for-service normalization factors, and changes to Star Ratings, the benchmark rate will decrease by 0.16%.[vii]

MA plans incentivize team-based care, resulting in the provision of the right care at the right time. Congress should carefully consider any MA policy changes to ensure they do not negatively impact care.

Ensure Provider Access to Administrative Claims Data
AMGA has conducted five risk-readiness surveys of its membership to obtain a snapshot of the progress and challenges providers face during this transformation of the U.S. healthcare system. In the surveys, AMGA members repeatedly expressed concern with the lack of access to timely federal and commercial payer administrative claims data. Last year, the Senate Health, Education, Labor and Pensions Committee approved an AMGA-endorsed amendment to S. 133, the Pharmacy Benefit Manager Reform Act by Sen. Markwayne Mullin (R-OK), to require commercial payers to provide claims data to providers. Congress should pass this provision into law as soon as possible. The administration has already made strides in this policy realm. Earlier this year, CMS finalized a rule to require MA, select Affordable Care Act plans, and other public payers to share claims and other patient data with providers through an application program interface (API).

Improve Care for the Chronically Ill
Chronic care management (CCM) is an essential part of coordinated care. In 2015, Medicare began reimbursing providers for CCM under a separate code in the Medicare Physician Fee Schedule. This code is designed to reimburse providers for primarily non-face-to-face care management. Under current policy, however, Medicare beneficiaries are subject to a 20% coinsurance requirement to receive the service. The latest data reveals that only 4% of Medicare beneficiaries potentially eligible for CCM received these services. That amounts to 882,000 out of a potential pool of 22.5 million CCM-eligible beneficiaries.[viii] Removing the coinsurance payment requirement would facilitate more comprehensive management of chronic care conditions and improve the health of Medicare patients. Additionally, removing patient coinsurance may facilitate greater care coordination for vulnerable patient populations.

Congress must approve legislation similar to the Chronic Care Management Improvement Act of 2023 (H.R. 2829), which would waive the current CCM code coinsurance requirements for Medicare beneficiaries.

Thank you for considering our recommendations, and we look forward to working with you throughout the year. If we can provide you with more information, please contact me or AMGA's Senior Director of Government Relations Jamie Miller at jmiller@amga.org.

Sincerely,

Jerry Penso, MD, MBA
President and Chief Executive Officer
AMGA

[i] AMGA, Stop the Cuts Survey Results, 2024, amga.org/getmedia/75400037-5d72-48e9-94e0-bedf7fb2dd73/AMGA_CY24_MA_Advance_Notice_Final_3-6-23.pdf

[ii] Congressional Budget Office, (2021, February 21), Letter to Honorable Kevin McCarthy, Potential Statutory Pay-As-You-Go Effects of the American Rescue Plan Act of 2021, cbo.gov/system/files/2021-02/57030-McCarthy.pdf

[iii] Centers for Medicare & Medicaid Services, (2023, August 24), Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-quality Care (Press Release), cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-18-billion-2022-and-continues-deliver-high

[iv] Ochieng, et. al., 2023, A Snapshot of Sources of Coverage Among Medicare Beneficiaries, KFF, kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/#:~:text=In%202021%2C%20Medicare%20Advantage%20covered,%25%20of%20all%20eligible%20beneficiaries

[v] Better Medicare Alliance, 2023, *State of Medicare Advantage 2023 Report*, BMA, bettermedicarealliance.org/publication/state-of-medicare-advantage-2023/

[vi] AMGA comments on "Medicare Advance Notice," (2023, March 6), amga.org/getmedia/75400037-5d72-48e9-94e0-bedf7fb2dd73/AMGA_CY24_MA_Advance_Notice_Final_3-6-23.pdf

[vii] AMGA comments on "Medicare Advance Notice". (2024, March 1), MA_2025_Advance_Notice_Comment_Letter.pdf (amga.org)

[viii] Office for the Assistant Secretary of Planning and Evaluation, (2022, March 1), "CCM-TCM Descriptive Data Analysis", aspe.hhs.gov/sites/default/files/documents/31b7d0eeb7decf52f95d569ada0733b4/CCM-TCM-Descriptive-Analysis.pdf