



Advancing High Performance Health

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May 26, 2021

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Brooks-LaSure:

On behalf of AMGA, I would like to congratulate you on your Senate confirmation as Administrator for the Centers for Medicare & Medicaid Services (CMS). AMGA and its membership stand ready to serve as a resource and partner. 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. I am confident that with your leadership and the on-the-ground experience of our members, along with the appropriate support and reforms, we can demonstrate how innovation, value-based models, and population-based health care can result in a healthier America.

President Joe Biden has established a number of goals for the nation's healthcare system. His January 28 Executive Order, *Strengthening Americans' Access to Quality, Affordable Health Care*, emphasized the need to make the healthcare system easier to navigate and more equitable. Based on our members' experience, there are several lessons that should inform Medicare policy to help achieve President Biden's goals.

We are pleased to offer these recommendations for your consideration.

Key Recommendations

- **Telehealth:** CMS telehealth policies should reflect the changes in care delivery resulting from the COVID-19 pandemic. While AMGA appreciates the statutory limitations in place, **CMS should use its authority to the fullest extent possible to eliminate the geographic and originating site requirements for telehealth services, particularly for those providers in alternative payment models. Payment parity between telehealth and in-person services is also needed, as the resources required to deliver care do not change depending on modality.** CMS should also continue to implement policies that support audio-only services, which will help provide access to care to those who would otherwise go without it, particularly those without access to reliable broadband internet.

- **Transition to Value:** AMGA and its membership strongly support the transition to value-based care. **To support our members' ability to deliver care through alternative payment models, CMS should offer a harmonized portfolio of models that work together to improve quality and reduce spending.** The models' features should complement each other and offer providers the tools needed to deliver care in a value-based reimbursement structure. Flexibilities such as telehealth, preferred provider lists, physician self-referral exceptions, and beneficiary incentive programs should not be restricted or limited based on the level of risk in a given model. As providers take on increased levels of financial risk, the framework and flexibilities offered by the model should not change fundamentally.
- **Chronic Care Management:** Medicare should further support care coordination efforts by eliminating the 20% coinsurance requirement for Chronic Care Management (CCM) codes, which reimburse providers for primarily non-face-to-face care management. This cost-sharing requirement acts as a barrier to more effective care planning.
- **Administrative Simplification:** AMGA supports policies that reduce the Medicare programs' regulatory complexity so our member providers are better able to focus on providing the best possible patient care, rather than divert their attention toward regulatory compliance activities that do not improve patient experience. **AMGA recommends that CMS design and implement regulations that encourage providers to innovate.** In addition, CMS policies should ensure that documentation and claims processing systems reflect provider workflow and care management needs. **For example, Medicare Advantage (MA) plans should process claims for administering COVID-19 vaccinations and report any necessary data to CMS.**
- **Access to Data:** Population health and care coordination efforts rely on the timely access to data, including claims data. Providers need a total view of the care their patients have received. High-quality data is critical not only for quality improvement efforts, but also for care coordination and management purposes. Providers require real-time access to data, including commercial claims data. **CMS should require payers to share all administrative claims data with providers, and AMGA believes application programming interfaces (APIs) can help facilitate such information sharing.**
- **Medicare Advantage:** AMGA is a strong supporter of the Medicare Advantage (MA) program. The program continues to grow in popularity, given its ability to offer supplemental benefits that go beyond those that are primarily health related and its potential to address social determinants of health. **CMS should continue to support the MA program by ensuring payments accurately reflect the health status of enrollees. In addition, CMS should minimize the effect of the coding intensity adjustment.**
- **Hospital at Home:** In response to the COVID-19 pandemic, CMS expanded the Acute Hospital Care At Home program. Based on our members' experience with the program, **AMGA recommends that CMS permanently expand the program and reimburse care through the diagnosis related group system, like any other hospital admission.**

AMGA stands ready to work with you and your team at CMS. Additional details on our key recommendations are offered below for your consideration.

Telehealth

The COVID-19 pandemic required AMGA members to reevaluate how they deliver care to their patients. One of the changes was the broad adoption and use of telehealth services. Congress and CMS waived a number of policies to permit providers to offer telehealth services during the COVID-19 Public Health Emergency (PHE). These waivers shifted how patients interact with their providers. Although accessing care via telehealth was linked to the PHE, patients will expect to have this option after the end of the pandemic.

AMGA understands that Congress will need to act to modernize the statutes governing the Medicare telehealth benefit. However, your leadership on this issue would prove invaluable. As you indicated during your confirmation hearing before the Senate Finance Committee, the pandemic has provided an opportunity to reexamine Medicare policies, including those for telehealth. AMGA appreciates your support for the need to reform Medicare's telehealth benefit.

During your confirmation hearing, you expressed a willingness to reevaluate CMS' authority surrounding telehealth. We would be pleased to share insights from our membership on how a reformed regulatory structure can support their ability to deliver clinically appropriate care remotely. Our members report that the types of services available via telehealth are expanding. While providers started with a limited set of services, largely for patients with less complex care needs, they are increasingly providing a more robust set of services via telehealth. Several policies would hinder the ability of providers and patients to use telehealth if they are reinstated at the end of the PHE.

Although the Medicare telehealth benefit currently is waived due to the COVID-19 PHE, AMGA strongly recommends that it not be limited by the current geographic and originating site restrictions. Medicare beneficiaries across the nation, regardless of their location, should have the opportunity to receive care in the most clinically appropriate manner, including via telehealth. In addition, the pandemic has proven that patients can safely and conveniently receive care in their homes. Medicare policy should support patients' ability to continue to receive such care.

In addition, Medicare reimbursement for telehealth services must recognize that the provider costs and resources needed to provide care via telehealth is effectively the same as for in-person care. There needs to be payment parity between care delivered in-person and via telehealth.

AMGA members also learned how audio-only care may be the only viable remote care option, particularly in rural areas. AMGA recommends that CMS continue separate payment for audio-only services. In addition, the relative value units for these audio-only codes should be comparable to telehealth and in-person services. AMGA also recommends that these audio-only visits satisfy the face-to-face requirement for collecting diagnoses for risk-adjustment and care coordination purposes.

Transition to Value

AMGA and its membership strongly support the transition to value-based care. However, the

competencies needed to deliver care in a value-based system require significant investments in appropriate infrastructure, personnel, and technology. Implementing value-based models also requires a learning curve to determine what processes and procedures are successful and which do not suffice for population health efforts.

Congress and President Obama envisioned a transition to value-based care with the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. AMGA and its membership have learned a significant amount about value-based care since MACRA's enactment. Our experiences with COVID-19 have also demonstrated what policy reforms offer the best support for providers that deliver care in value-based models or alternative payment models (APMs).

CMS regulations that were developed and implemented in the fee-for-service environment do not account for the underlying incentives of value-based care models, including those that are shared-savings only. Value-based models should offer regulatory flexibilities based on the understanding that the volume concerns in a fee-for-service environment are not applicable. Limiting waivers and beneficiary incentive opportunities to only models with downside risk is a disservice to providers, patients, and the Medicare program. Instead, CMS should base its alternative payment models (or value-based models) on a common set of regulatory requirements and flexibilities that do not vary based on the level of risk. If regulatory flexibilities within a model are linked to the level of risk, providers need to adjust their practice patterns and care delivery models on a new regulatory structure. This is counterproductive and serves as a disincentive to participation.

In addition to offering new alternative payment models, MACRA also reformed the Medicare fee-for-service reimbursement system through the Merit-based Incentive Payment System (MIPS), which originally was intended to serve as a transition to value-based models. By linking payment adjustments to quality, cost, electronic health record use, and other improvement activities, MIPS introduced a level of value-based reimbursement into fee-for-service Medicare payments. Unfortunately, since its inception, CMS' low-volume threshold—which excludes providers from participation in MIPS—has undermined the program and providers' ability to earn a meaningful payment adjustment. AMGA has long opposed the continuation of the low-volume threshold because of concerns that the number of clinicians excused from MIPS remains high. Due to the budget-neutral nature of MIPS, excluding such a large number of clinicians, who would otherwise be required to participate in MIPS, will continue to have adverse consequences on both those who participate in the program and those who do not. AMGA must reiterate our concern that such negligible payment adjustments do not reflect the considerable investments our members have made in transitioning to a payment system that is based on the quality and cost of care provided. The low-volume threshold should be removed from the program.

Chronic Care Management

Chronic Care Management (CCM) services are comprehensive care coordination services provided each calendar month to beneficiaries with two or more chronic conditions. In recognition of the importance of chronic care management, Medicare created separate billing codes under the Physician Fee Schedule to support providers' care coordination efforts. AMGA supported this change. However, Medicare beneficiaries are responsible for a 20% coinsurance when they receive CCM services, which may deter them from consenting to receive these services. Also, as these services are primarily non-face-to-face, beneficiaries may be confused as

to why they are receiving a bill for a visit they do not remember occurring. For these reasons, the 20% coinsurance for these services should be eliminated.

AMGA encourages CMS to work with Congress to enact legislation that removes the cost-sharing requirement for CCM services. In the meantime, CMS should explore its authority to waive the coinsurance requirement. CMS has waived cost sharing in the instance of beneficiaries receiving opioid use disorder treatment furnished by opioid treatment programs. While we understand that CMS provided this flexibility through the SUPPORT Act, it creates a precedent for other services that are vitally important to beneficiaries who have multiple chronic conditions.

Administrative Simplification

AMGA supports efforts to streamline regulations and administrative requirements so that they support our members' ability to deliver high-quality care. We offer detailed comments in an [April 20 letter to the Center for Medicare and Medicaid Innovation](#) on how this is particularly important for providers in value-based care models.

AMGA is concerned that CMS' policy of requiring providers to submit COVID-19 vaccine related claims for MA patients through the fee-for-service claims processing system adds an unnecessary burden to providers. For 2020 and 2021, Medicare payment for administering COVID-19 vaccines for MA plan members will be made through the original fee-for-service Medicare program. As a result, providers must submit claims for administering the COVID-19 vaccine to their CMS Medicare Administrative Contractor using product-specific codes for each vaccine approved. This requires our members to collect Medicare numbers from their patients, which causes unnecessary work and confusion for patients. MA plans should process claims for administering COVID-19 vaccinations and report any necessary data to CMS.

AMGA appreciates that CMS has delayed the Appropriate Use Criteria (AUC) requirement until January 1, 2022. The AUC program requires providers who order advanced diagnostic imaging for Medicare patients to consult a qualified Clinical Decision Support Mechanism (CDSM) before ordering the imaging test. Although providers are required to consult the CDSM, they are not required to follow its recommendations. AMGA encourages CMS to delay this requirement beyond 2022. In addition, as the incentives underlying the rationale behind the AUC requirement are not present in value-based models of care, the requirement to consult a CDSM should not be imposed on providers who order advanced diagnostic imaging as part of a value-based model.

Access to Administrative Claims Data

Access to claims data, including commercial claims data, would provide AMGA members with a broader perspective on all the services a patient has received. Electronic medical records do not always capture all the care a patient receives, such as preventive screening exams and tests. This is particularly true if these service are provided by a clinician who does not have a relationship with one of our members. Payers, however, have data on the types of services their enrollees have received. The payer has a record of every encounter and every prescription filled, unless the care is paid entirely on an out of pocket basis. Sharing this data would offer providers the ability to view all of the care a patient has received. Reviewing this data will inform providers' care decisions and has the benefit of helping to reduce test redundancies and unnecessary procedures.

Relying solely on clinical data in a provider's medical records is insufficient to develop a population health strategy. However, when paired with claims data, providers have a powerful tool to manage the health of a population, particularly for chronic disease. CMS should require that payers share all administrative claims data with providers, and AMGA believes APIs can help facilitate such information sharing.

Medicare Advantage

MA, with its supplemental benefits and cap on out-of-pocket costs, provides an attractive benefit package for beneficiaries and offers providers flexibilities that are not available under fee-for-service Medicare. As a result, the program remains incredibly popular—the program currently enrolls 25 million beneficiaries and is expected to account for 46.5% of all Medicare beneficiaries by 2025. AMGA member groups see the value and stability of the MA program, as the program provides a consistent set of rules and a stable financing mechanism, which enables our members to focus on delivering high-quality care that encourages care coordination. AMGA recommends that CMS continue to provide flexibility for MA plans. AMGA recommends that CMS continue to support the MA plan's flexibility in benefit design. In addition, CMS should continue to minimize the effect of any mandated coding intensity adjustment. Finally, as previously noted, audio-only care should satisfy the face-to-face requirement for collecting diagnoses for risk-adjustment and care coordination purposes.

Hospital at Home

The Acute Hospital at Home program is an expansion of the CMS Hospital Without Walls initiative, which is part of the agency's response to COVID-19 and a way to increase hospital capacity by allowing patients to receive select procedures outside at their home. As previously noted, AMGA strongly supports reducing regulatory barriers that support our members' ability to deliver care in innovative ways. Similar to how telehealth has opened new ways to care for patients, the Acute Hospital at Home program also eliminates barriers that otherwise would keep patients from receiving high quality care in their own homes. The initiative makes available a waiver of the Medicare Conditions of Participation that nursing services be provided on premises 24/7 and requires the immediate availability of a registered nurse for the care of any patient. CMS has identified more than 60 acute care conditions that can be treated at home under this model.

Based on our members' experience with the program, AMGA recommends that CMS maintain the flexibilities by permanently including the model in the Medicare program. Medicare should reimburse for services provided as part of the model through the diagnosis related group system. The model has shown to be an effective way to reduce costs and readmissions, while also improving patient care experience.ⁱ This model is particularly important for rural communities and should be available to those rural hospitals that have converted to the Rural Emergency Hospital (REH) designation, which Congress authorized as part of the Consolidated Appropriation Act, 2021. Such facilities should have the ability to participate in the hospital-at-home model and bill under the DRG system.

Thank you for supporting policies that ensure providers have the resources they need to care for patients during this public health crisis. If we can provide you with any more information, please feel free to contact me or AMGA's Chief Policy Officer Chet Speed at cspeed@amga.org.

Sincerely,



Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer
AMGA

ⁱ Annals of Internal Medicine, “[**Hospital-Level Care at Home for Acutely Ill Adults**](#): A Randomized Controlled Trial,” David M. Levine, Kei Ouchi, et. al, Jan. 21, 2020.