Advancing High Performance Health

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

Dear Speaker Pelosi;

On behalf of AMGA, I would like to thank you for assisting our members and other healthcare providers as they continue to battle the novel coronavirus (COVID-19) pandemic. 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 medical groups and integrated systems have been on the front lines of this public health emergency from the beginning and have overcome a number of obstacles to continue providing high-quality, cost-effective, and patient-centered medical care. With the total impact of this continuing pandemic unknown, it is critical that our members remain stable to provide optimal care. In addition, our members continue to invest in value-based care throughout their communities and deliver high-quality care to their patient population. It is important that your deliberations this fall consider the medical group model.

AMGA would like to share our views on the most critical issues for multispecialty medical groups and integrated delivery systems, including:

- Stopping potential cuts to Medicare
    - Eliminating Medicare Pay-As-You-Go (PAYGO) cuts
    - Delaying Medicare sequestration cuts
    - Addressing the decrease in Medicare conversion factor
- Preserving Medicare Advantage (MA)
- Promoting telehealth
- Providing a pathway to value
    - Improving care for the chronically ill
    - Reforming Accountable Care Organizations (ACOs)
    - Ensuring provider access to administrative claims data

Stopping Potential Cuts to Medicare

Recent Congressional spending bills signed into law have triggered certain spending cuts that put Medicare patients and providers at risk at the worst possible time. Providers are currently facing the potential of up to a 10% cut to Medicare reimbursement at the end of the year, barring Congressional action.

Medicare PAYGO cuts

The American Rescue Plan Act of 2021 increased spending without offsets to other federal programs. Under Statutory PAYGO rules, any increases to the federal deficit automatically triggers an additional series of across-the-board deductions to federal programs. Without Congressional action, PAYGO would include up to 4% in reductions to Medicare payment set to occur on January 1, 2022.

Medicare Sequester Delay Extension

At the onset of the COVID-19 pandemic, Congress delayed the automatic 2% Medicare sequestration cuts, as providers were struggling to keep their doors open to their communities. Various delays were enacted during this public health emergency, with the last pause setting to expire on January 1, 2022. If Congress does not extend the moratorium on the sequester cut prior to 2022, it appears Medicare reimbursements would be cut an additional 2%.

Decrease in Medicare Conversion Factor

Last year, due to a temporary patch approved by Congress, the Centers for Medicare & Medicaid Services (CMS) increased all providers' payments by 3.75% to offset a change in the Medicare conversion factor that CMS implemented as part of a change to Evaluation and Management (E/M) codes designed to increase support for primary care services. In the 2022 CMS Physician Fee Schedule proposed rule, the agency is reducing the Medicare conversion factor by 3.75%, due to these E/M policy changes.

To ensure Medicare beneficiaries maintain access to their providers, Congress must clear the PAYGO "scorecard" resulting from passage of the American Rescue Plan and ensure no further PAYGO cuts occur this year. Congress also must approve legislation that suspends Medicare sequestration cuts in 2022. In addition, policymakers need to approve into law a policy that provides a 3.75% increase to Medicare reimbursements to compensate for the cuts in the CMS Physician Fee Schedule Rule. Together, all of these actions would prevent the looming 10% cut that providers face next year.

Preserving MA

Today, 42% of all Medicare beneficiaries have enrolled in MA plans, and AMGA members care for many of these patients.[i] As a financing model that emphasizes preventative care and value, MA plans align with both the multispecialty medical group and integrated delivery system models, resulting in improved care at a reduced cost.[ii] MA structure supports the team-based, multispecialty medical group and integrated delivery system approach, resulting in the right care at the right time. Congress should carefully consider any MA policy changes to ensure that they do not negatively impact care, which can disproportionally affect minority beneficiaries and those with social risk factors, as those beneficiaries are served more by MA plans than by traditional Medicare fee-for-service.[iii]

Promoting Telehealth

At the beginning of this pandemic, AMGA members altered the way they deliver care by eliminating elective surgeries and procedures and keeping patients away from their facilities. As a result, a significant expansion of telehealth services has occurred, allowing providers to reach patients in unprecedented ways. For example, our members reported an increase from 10 telehealth visits per month to an average

of 2,000 telehealth visits per week. After more than a year of the pandemic, our members' patients have come to expect telehealth services as a standard of care delivered by their provider. Congress needs to ensure that this service remains available to all patients and that AMGA members can use the technology as part of their innovative delivery models, which promote patient convenience and safety.

Through the *Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020*, Congress waived Medicare's telehealth originating site and geographic limitations. In addition, CMS expanded the number of services that qualify for telehealth, while also increasing payments for telehealth so that reimbursement is the same as for in-person services. CMS also recognized the need for patients without smartphones or computers to access care while staying at home by creating a set of audio-only codes for select services. Congress should now recognize the important role that telehealth has in a modern healthcare system and permanently authorize all of these policies.

Additionally, policymakers need to ensure that payment parity between telehealth services, including audio-only services and in-office visits, continues beyond this pandemic. AMGA also recommends that these audio-only visits satisfy the face-to-face requirement for collecting diagnoses for risk-adjustment and care coordination purposes.

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

To address these telehealth policy areas, Congress must approve the following bills or any additional policies that promote the use of telehealth services.

- The *Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021* (H.R. 2903/ S.1512), which would permanently remove all geographic restrictions on telehealth services and expand originating sites to include the home and other sites
- The *Telehealth Modernization Act* (H.R. 1332/S. 368), which would permanently eliminate geographic and originating site restrictions and expand the types of telehealth services covered by Medicare
- The *Ensuring Parity in MA Audio-Only Telehealth Act (*H.R. 2116/S. 150), which would permit audio-only diagnoses that are made via telehealth to be used for purposes of determining risk adjustments to payments under MA
- The *Temporary Reciprocity to Ensure Access to Treatment (TREAT) Act* (H.R. 708/S. 168), which would enable healthcare professionals to provide telehealth services across state lines during the COVID-19 pandemic by providing state licensing reciprocity.

Pathway to Value

Both Congress and the administration have made clear the necessity of transforming the way health care is financed and delivered. Policymakers must address significant obstacles and challenges that exist in the healthcare market so that AMGA members can continue providing high-quality, cost-effective, and patient-centered medical care.

Improving Care for the Chronically Ill

Chronic care management (CCM) is an important 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, Medicare beneficiaries are subject to a 20% coinsurance requirement to receive the service. Consequently, only 684,000 patients out of 35 million eligible Medicare beneficiaries with two or more chronic conditions benefitted from CCM services over the first two years of the payment policy.

Removing the coinsurance payment requirement would facilitate more comprehensive management of chronic care conditions and improve the health of Medicare patients. Providers and care managers have discovered several positive outcomes for CCM beneficiaries, including improved patient satisfaction and adherence to recommended therapies, improved clinician efficiency, and decreased hospitalizations and emergency department visits. Congress must approve the *Seniors' Chronic Care Management Improvement Act of 2021 (*H.R. 4755), which would waive the current CCM code coinsurance requirements for Medicare beneficiaries.

Reforming ACOs

Just recently, CMS announced that the Medicare Shared Savings Program (MSSP) has generated $1.9 billion in total net savings in 2020, which makes four consecutive years of savings for the federal ACO program.[iv] ACOs have also increased quality of care for patients. Despite this welcome news, there remain significant obstacles in program design that threaten the future viability of the program.

One impediment is that CMS currently includes all beneficiaries in the regional adjustment factor that is used to calculate an ACO's benchmark, which is a disadvantage to ACOs that perform well relative to the rest of their region. To remedy this situation, policymakers should remove an ACO's population from CMS' regional adjustment calculation, which would reward them for delivering higher quality, lower cost care, regardless of their geographic location. Additionally, Congress should increase the shared savings rates for ACOs in the MSSP, update risk adjustment rules, eliminate the artificial distinction between "high" and "low" revenue ACOs, and reinstate the ACO Investment Model. Lastly, the 5% Advanced Alternative Payment Model (APM) incentive payments under the *Medicare Access to CHIP Reauthorization Act of 2015* are expiring soon and should be extended for at least another six years.

Congress should approve the *Value in Health Care Act of 2021* (H.R. 4587) and the *Accountable Care in Rural America Act* (H.R. 3746), which would improve and strengthen the MSSP program and extend APM incentives.

Ensuring Provider Access to Data

AMGA has conducted four 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. To ensure the successful transition from volume to value, legislators must address significant obstacles in the healthcare market identified in the survey results. In the surveys, AMGA members repeatedly expressed concern with the lack of access to timely federal and commercial payer administrative claims data.

Last Congress, the Senate Health, Education, Labor and Pensions (HELP) Committee included a provision in the *Lower Health Care Costs Act* that would allow providers to access commercial payers'

administrative claims data. While not included in the final law, studies have shown that if providers have access to commercial claims data, they are able to understand what services their patients utilize outside of their practices, allowing them to create better care management plans for their patients.[v] Policymakers should require federal and commercial payers to provide access to all administrative claims data to healthcare providers.

Thank you for supporting policies that ensure providers have the resources they need to care for patients during this public health crisis and beyond. 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] Fuglesten Biniek , Jeannie, et al. "Medicare Advantage IN 2021: Enrollment Update and Key Trends." *KFF*, Kaiser Family Foundation, 24 June 2021, www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/.

[ii] "Medicare Advantage Outperforms Traditional Medicare on ..." *Better Medicare Alliance*, Better Medicare Alliance, 30 Mar. 2021, bettermedicarealliance.org/wp-content/uploads/2021/03/BMA_Modest_LowIncome_Report.pdf.

[iii] Ibid

[iv] https://www.cms.gov/newsroom/press-releases/affordable-care-acts-shared-savings-program-continues-improve-quality-care-while-saving-medicare

[v] U.S. Government Accountability Office. (2018, December). *Medicare: Voluntary and Mandatory Episode-Based Payment Models and Their Participants* (Report No. GAO-19-156). Retrieved from https://www.gao.gov/assets/700/696264.pdf