Advancing High Performance Health

One Prince Street
Alexandria, VA 22314-3318
O 703.838.0033
F 703.548.1890

2021 Issue Brief

Pathway to Value

Issue

The healthcare landscape is in the midst of a transition to value-based care and reimbursement. Over the past several years, federal policymakers have embarked on this ambitious transformation in healthcare financing and care delivery through various laws and policies. 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.

Ensuring Access to Care for the Chronically Ill

Chronic care management (CCM) is an important part of coordinated care and remains a key issue as patients gain and maintain access to quality 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.

Improving Federal Accountable Care Organization (ACO) Program

Though many ACOs have saved Medicare dollars and increased overall quality, ACOs have encountered significant obstacles in program design that threaten the future viability of the program.

One impediment is that the Centers for Medicare & Medicaid Services (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. This change will result in more ACOs participating in the Medicare Shared Savings Program (MSSP) and 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. Also, 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.

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. This provision was not included in the final law, but 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.[i]

AMGA asks Congress to:

- **Approve H.R. 4755, the *Seniors' Chronic Care Management Improvement Act of 2021,* which would waive the current CCM code coinsurance requirements for Medicare beneficiaries.**
- **Approve the H.R. 4587, the *Value in Health Care Act of 2021* and H.R. 3746, the *Accountable Care in Rural America Act,* which would improve and strengthen the MSSP program and extend APM incentives.**
- **Require federal and commercial payers to provide access to all administrative claims data to healthcare providers.**

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[i] 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