No Playing Around

AMGA's 2023 legislative priorities

By Madison Schultz

As a new Congress takes over and leadership shifts in Washington, multispecialty medical groups and integrated systems of care throughout the country still face many of the same challenges since the onset of the COVID-19 pandemic. While many temporary solutions have been implemented, the fight to support the healthcare community continues as the temporary fixes expire.

In 2023, AMGA continues to urge Congress to address the critical issues that face the patient-provider community and impede the move to value. Furthermore, AMGA has shared a letter to House and Senate leadership on legislative priorities that Congress should address this year.

1 Sustaining the Medicare Program and Provide a Pathway to Value

The Medicare program has faced various threats in the past two years, and AMGA members were on the front lines of their impact. Since 2021, providers yearly have faced up to 10% cuts to Medicare reimbursement. While Congress took action to delay some of these cuts, the threat remains as the cuts are scheduled to resume on December 31, 2024. Providers and their patients rely on the stability of the Medicare program, and additional action to address the cuts is urgent. More broadly, the continuation of this threat impedes the transition to value-based care. A more sustainable system must be developed and adopted so that patient communities maintain access to quality care.

2 Improve and Incentivize Value-Based Models of Care

To help support providers in the move to value-based care, policymakers should continue investing in incentive programs such as the 5% Advanced Alternative Payment Model (APM). Established through the Medicare Access to CHIP Reauthorization Act (MACRA) of 2015, the 5% Advanced APM bonus payment incentivizes providers to participate in high-quality, cost-efficient care. Participating eligibility was set to expire in 2022, but Congress extended the program for an additional

year at a 3.5% bonus. Congress should continue to support programs like this, as value-based care models are proven to generate government savings. The Medicare Shared Savings Program (MSSP), for example, is an effective value-based program, saving the Medicare program $1.66 billion in 2021, which marked the fifth consecutive year it generated overall savings compared to expected Medicare expenditures.[1] Furthermore, AMGA believes policymakers must establish a more stable Advanced APM program to continue incentivizing providers to move to value.

3 Invest in Infrastructure

While AMGA strongly supports the transition to value, we understand it requires capital investments in infrastructure and cultural change. Currently, providers do not receive bonus payments under many value-based contracts until six to eight months after a measurement period ends. Advanced funds are imperative in making the systemic improvements needed to ensure patients get the right care at the right time. AMGA recommends that Congress fund upfront cost reimbursement to support members' transitions to value-based care.

4 Incentivize Patient Engagement

In value-based care, patients take a more active role in their comprehensive health. To encourage improved patient-provider relationships, AMGA believes that Congress should put measures in place to incentivize patient participation, such as reducing premiums, waiving copays for services, and ensuring access to providers through telehealth care. Congress should also focus on providing financial incentives to enable patients to actively participate and improve their health. Providing incentives to engage patients in their health outside the healthcare system will also help providers make the most of their limited time with their patients.

5 Promote End-of-Life Care

End-of-life care is physically and emotionally taxing for patients and their loved ones. As the palliative care process uses a team approach, primary care providers should be incentivized to participate in this process and conversations to guarantee comprehensive, high-level care delivery. This level of care requires additional time and attention to the patient, and reimbursement should reflect this process.

6 Promoting Telehealth

When the pandemic began in 2020, providers faced many challenges but ultimately were able to continue providing care through telehealth services. Telehealth utilization has increased exponentially in the past three years, with patients and providers relying on remote care coordination. For example, some AMGA members have reported going from 10 telehealth visits per month to an average of 2,000 telehealth visits a week. Despite the expiration of the public health emergency (PHE) this May, telehealth services must remain in place permanently.

Last year, Congress approved legislation to waive Medicare's telehealth originating site and geographic limitations for an additional two years, through December 31, 2024. Additionally, the law extended recognition of audio-only payments in that same period. While this action provides temporary assurance that telehealth visits may continue, a permanent solution would guarantee consistent patient access to care.

A recent survey found that if payments were reduced, 92% of AMGA members would not be able to provide the same level of telehealth services and patient access.[2] These comments signify a need for payment parity in telehealth services so patients can continue receiving telehealth services. As AMGA advocates for telehealth permanence, we also are asking Congress to recognize the need for reimbursement policies such as payment parity between in-office, telehealth, and audio-only visits. Likewise, audio-only diagnoses made through telehealth should be factored into Medicare Advantage risk adjustments. Additionally, federal licensing and credentialing standards for telehealth services should be established to ensure care can be delivered regardless of geographic location.

7 Preserving Medicare Advantage

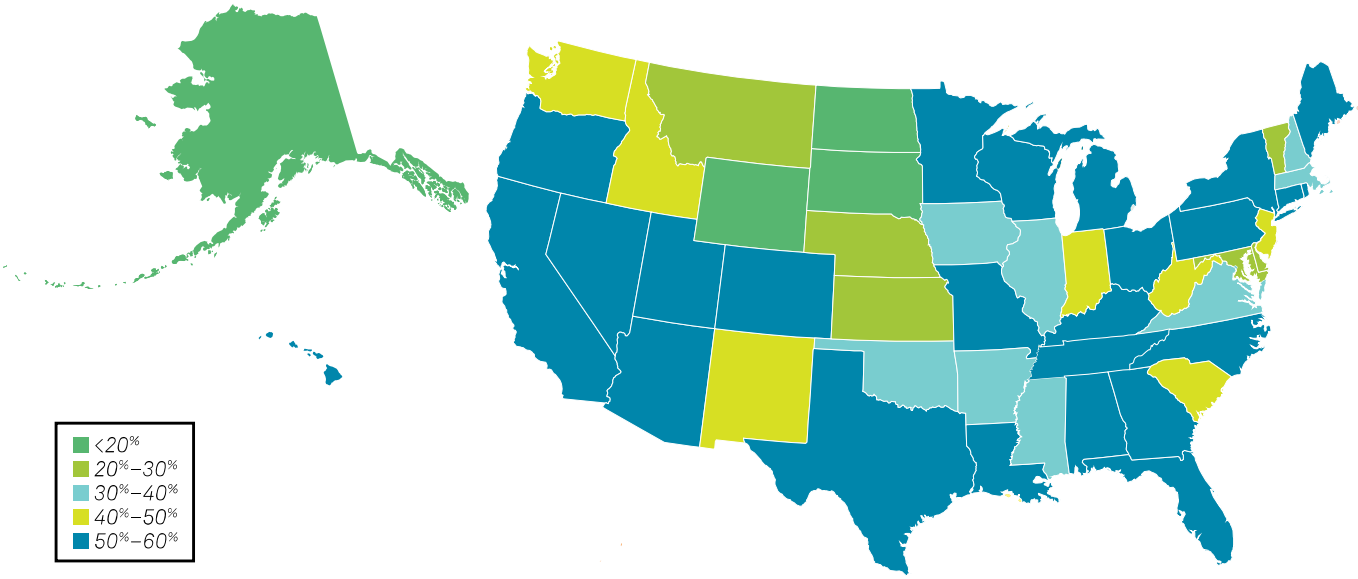
As policymakers continue to consider the viability of healthcare programs, AMGA is working to ensure that Congress does not make cuts to Medicare Advantage (MA). MA is a financing model that emphasizes preventative care and value, resulting in improved care at a reduced cost, which aligns with the goals of multispecialty medical groups and integrated systems of care. Likewise, MA plans incentivize team-based care and help providers deliver the right care at the right time. Today, 48% of changes to the MA program could have a disproportionate impact on minority beneficiaries and those with social risk factors, as MA plans serve those beneficiaries more than traditional Medicare fee-for-service.[3]

8 Promoting Health Equity

AMGA believes equitable access to quality care for all patient populations is essential to patient-centered, value-based care. Social determinants of health (SDOH), which are defined as the "conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes,"[4] must be considered a vital factor in achieving health equity. To that end, AMGA encourages Congress to establish legislative frameworks that acknowledge the total cost of treatment, which includes addressing SDOH and the health equity issues they can cause.

Figure 1

Share of Beneficiaries Enrolled in Medicare Advantage in 2022



Source: Kaiser family Foundation analysis of CMS Medicare Advantage Enrollment Files, 2022 and March Medicare Enrollment Dashboard, 2022

9 Ensuring Provider Access to Administrative Claims Data

AMGA has conducted five annual risk-readiness surveys of its membership to better understand the progress and challenges that members face transitioning to value. The survey results indicated concern with the need for more access to timely federal and commercial payer administrative claims data. If providers had access to these data, they would better understand their patients' comprehensive health and therefore be able to create better care management plans for their patients. AMGA continues to pressure lawmakers to require federal and commercial payers to provide healthcare providers access to all administrative claims data.

10 Improving Care for the Chronically Ill

Chronic care management (CCM) is a vital aspect of coordinated care. AMGA has been at the forefront of this issue, highlighting the need to reform the underused Medicare CCM codes. In 2015, Medicare began reimbursing providers for CCM under a separate code in the Medicare Physician Fee Schedule, designed to reimburse providers for primarily non-face-to-face care management. As a result, Medicare beneficiaries are subject to a 20% coinsurance payment for the service. AMGA believes that removing the coinsurance payment requirement would facilitate more comprehensive management of chronic care conditions and improve the health of Medicare patients. AMGA is urging Congress to approve legislation waiving the current CCM code coinsurance requirements for Medicare beneficiaries.

Next Steps

This year, AMGA will continue to advocate for the medical group model of care delivery and the push toward value-based, patient-centered care. While the temporary actions taken to address some of these issues have been helpful, we believe policymakers should focus on long-term solutions to the aforementioned priorities. We will continue leveraging our lobbying efforts on Capitol Hill to ensure our members have the appropriate measures to serve their patients and provide high-quality care. GPJ

Madison Schultz *is coordinator, government relations, at AMGA.*
mschultz@amga.org

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