Political Animals

AMGA's legislative priorities

By Alicia Sawyer

Over the coming months, control of both chambers of Congress and the White House will be determined. In addition to the election season, turmoil persists within both chambers, but AMGA continues to promote value-based care (VBC) to policymakers, and opportunities to improve the healthcare system remain.

Recently, AMGA sent a letter to congressional leadership outlining priorities that must be addressed to ensure our medical groups and integrated systems of care continue to provide the highest quality care to their patients. The letter outlines the need to prevent further Medicare cuts, improve and incentivize value-based models of care, promote

telehealth, preserve Medicare Advantage (MA), ensure provider access to administrative claims data, and improve care for the chronically ill. These priorities ensure providers have the financial stability and regulatory flexibility necessary to meet the care needs of their patients while continuing the transition to VBC.

Sustain Medicare by Preventing Further Payment Cuts

Over the past few years, decreasing reimbursement rates, coupled with increased labor and supply chain costs, have made providing quality care increasingly difficult year after year. In fact, providers will face substantial cuts to Medicare at the end of the year absent congressional intervention.

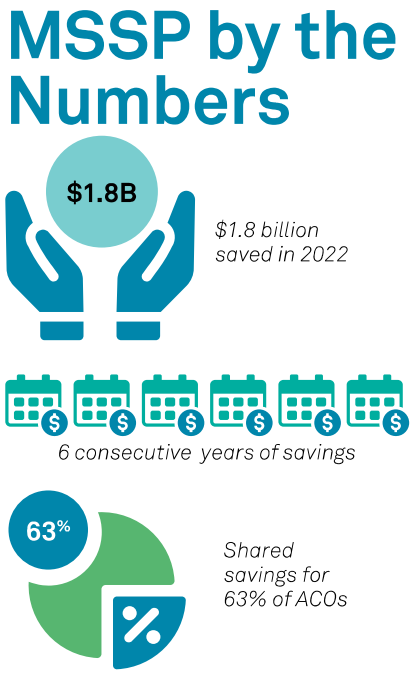
The first cut is to the Medicare Part B conversion factor, which has seen almost 8% in cuts over the past four years. Congress has provided partial relief to these cuts, but providers expect a larger conversion factor cut in 2025 than last year. In addition, providers could also be subject to a 4% or $36 billion cut to Medicare due to statutory Pay-As-You-Go (PAYGO) rules that was triggered upon the passage of the American Rescue Plan Act of 2021. PAYGO requires offsets when increased spending is approved into law.[1]

Congress delayed these PAYGO cuts the last three years. Still, by December 31, 2024, lawmakers must once again address this issue to ensure that providers' Medicare reimbursements are not cut substantially. Considering the impact of continued Medicare cuts on providers and their patients, AMGA urges Congressional action to prevent the proposed cuts.

Improve and Incentivize Value-Based Models of Care

The transition to value is a key priority for AMGA. The Centers for Medicare & Medicaid Services (CMS) recently announced that the Medicare Shared Savings Program (MSSP) saved the Medicare program $1.8 billion in 2022 compared to spending targets. This marks 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 the inception of the MSSP over 10 years ago. About 63% of participating Accountable Care Organizations (ACOs) earned shared savings payments for their performance in 2022.[2]

The success of the MSSP demonstrates the importance of the 5% Advanced Alternative Payment Model (APM) incentive payment in the Medicare Access and CHIP Reauthorization Act. Due to AMGA's advocacy, Congress temporarily extended the eligibility to earn incentive payments, which is set to expire at the end of 2024. The AMGA-endorsed Value in Healthcare (VALUE) Act (H.R. 5013/S. 3503) seeks to extend the 5% Advanced APM incentive payments for an additional two years. The legislation also strengthens the MSSP by eliminating the high-low revenue designation for ACOs, establishing benchmark transparency guardrails, and creates a voluntary, full-risk MSSP option. AMGA believes that legislators must extend the incentive payment program and implement reforms to the ACO program by passing the VALUE Act.



Promote Telehealth

AMGA urges Congress to recognize how the pandemic has altered care delivery by permanently waiving geographic limitations and originating site regulations, ensuring payment parity between in-office and telehealth services, continuing payment for audio-only services, removing state licensing restrictions for telehealth services, and protecting the privacy of providers' home addresses.

Through the Consolidated Appropriations Act of 2023, Congress waived Medicare's telehealth originating site and geographic limitations for an additional two years through December 31, 2024. The law also extended recognition of audio-only payments for that same period. Policymakers need to recognize the impact of telehealth reimbursement policies on patient access to quality care. Payment parity among in-office, telehealth, and audio-only should continue.

AMGA members have made significant investments in telehealth modalities and platforms to ensure patients have access to care. An AMGA-conducted survey supported this with 76% of providers responding that telehealth services are just as expensive or cost more than in-person services, and 92% responding they will be forced to limit telehealth services if reimbursement rates were reduced. AMGA believes policies supporting telehealth should be permanently extended to ensure greater patient access to care.

Additionally, AMGA urges Congress to address the requirement that providers to include their home addresses on Medicare enrollment and claims forms beginning January 1, 2025. AMGA believes that reporting home addresses poses a substantial security risk to providers.

AMGA members collaboratively provide care and need a standardized federal licensing and credentialing system for telehealth. This would ensure that the most suitable care

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team member can provide or suggest the most appropriate care to a patient, regardless of the state where a provider or patient resides. It is vital that Congress address these policies to ensure that providers continue to have the tools and resources they need to best serve their patients.

Preserve Medicare Advantage

MA beneficiaries represent more than half of Medicare patients.[3] 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 would remove distinct clinical differences from the model. The removal of codes from the HCC model would also have a significant impact on providers' financial stability and enrollee access to services.[4] For example, under the proposed CY 2025 Advance Notice, if CMS finalize 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%.[5] Any change to the MA program needs to assess the impact on patient access and quality of care.

Ensure Provider Access to Administrative Claims Data

AMGA conducted five risk readiness surveys of its membership to obtain an overview of the progress and challenges providers face in moving to risk-based payment models. Through the surveys, AMGA members stated that the biggest obstacle in moving to value was the lack of access to timely federal and commercial payer administrative claims data. Last year, the Senate Committee on Health, Education, Labor, and Pensions approved an AMGA-endorsed amendment to S. 1339, the Pharmacy Benefit Manager Reform Act, to require commercial payers to provide claims data to providers.

Earlier this year, CMS finalized a rule requiring MA, select Affordable Care Act plans, and other Federal 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 component of coordinated care. Under current policy, Medicare beneficiaries are subjected to a 20% coinsurance requirement to receive CCM services. This may cause Medicare beneficiaries to miss out on the service, as the latest data reveal only 4% of Medicare beneficiaries potentially eligible for CCM received care.[6]

AMGA believes the coinsurance payment requirement should be removed, giving Medicare patients with chronic conditions better and more comprehensive access to quality care. AMGA believes 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.

Conclusion

AMGA remains committed to advocating for the integrated system and medical group care delivery model, and advancing the transition towards value-based, patient-centered care. While short-term measures assisted in addressing certain issues, our emphasis is on advocating for enduring solutions to these priorities. Our continued advocacy on Capitol Hill seeks to secure the necessary support for our members to serve their patients and deliver high-quality, value-driven care effectively. GPJ

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