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Advancing Health in America

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October 31, 2022

The Honorable Ami Bera
U.S. House of Representatives
172 Cannon House Office Building
Washington, D.C. 20515

The Honorable Larry Bucshon
U.S. House of Representatives
2313 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Kim Schrier
U.S. House of Representatives
1123 Longworth House Office Building
Washington, D.C. 20515

The Honorable Michael Burgess
U.S. House of Representatives
2161 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Earl Blumenauer
U.S. House of Representatives
1111 Longworth House Office Building
Washington, D.C. 20515

The Honorable Brad Wenstrup
U.S. House of Representatives
2419 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Brad Schneider
U.S. House of Representatives
300 Cannon House Office Building
Washington, D.C. 20515

The Honorable Mariannette Miller-Meeks
U.S. House of Representatives
1716 Longworth House Office Building
Washington, D.C. 20515

Re: Request for Feedback on Stabilizing the Medicare Payment System

Dear Representatives Bera, Bucshon, Schrier, Burgess, Blumenauer, Wenstrup, Schneider and Miller-Meeks:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations; our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers; and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on opportunities to increase participation, enhance efficacy of Medicare Access and CHIP Reauthorization Act (MACRA) programs, and further transition our health care system from volume to value.

The COVID-19 pandemic has been an inflection point for the U.S. health care delivery system. Rising inflation and staffing shortages, among other factors, have put

unprecedented strain on hospitals and health systems. We are looking forward to a post-pandemic environment to provide an opportunity to stabilize and improve providers' financial outlooks and further the transition to value-based care.

Prior to the COVID-19 pandemic, adoption of the bipartisan MACRA was an important step in shifting the physician payment model from fee-for-service payment to reimbursement based on quality and value metrics. This legislation replaced the historical Sustainable Growth Rate (SGR) with the Quality Payment Program (QPP), which is comprised of two tracks: the default Merit-based Incentive Payment System (MIPS); and a track for clinicians who exhibit sufficient levels of participation in certain advanced alternative payment models (APMs).

The AHA has encouraged implementation and adoption of APMs using common principles of transparency; integrated care; balancing risk and incentives; mitigating fragmentation; reducing barriers to clinical integration and care coordination; supporting timely and actionable data; appropriately adjusting for risk; reducing regulatory burden; and leveraging partnerships, where appropriate. While the volume of providers participating in APMs has thus far been lower than anticipated, the impacts on reducing Medicare costs and improving patient outcomes have been noteworthy. For example, the Medicare Shared Savings Program has demonstrated positive improvement for participants in quality measures like preventative screening compliance, blood pressure and glucose management, flu vaccination rates, and statin therapy compliance[1]. In 2021, the Medicare Shared Savings Program generated over $1.6 billion in cost savings.

The AHA encourages statutory and regulatory efforts to further support flexible implementation and widespread adoption of value-based and alternative payment models. For example, the extension of APM incentive payments, additional investment in resources for rural providers, and updates to the physician fee schedule to support more inclusive definitions and updated metric methodologies (which we discuss more detail below), would all encourage higher rates of APM adoption among hospitals and health systems.

Advanced APMs

Extension of Advanced APM Incentive Payments

First, the AHA requests Congress act by extending the current timeline for advanced APM incentive payments. MACRA provides critical incentives for physicians who participate in advanced APMs, including lump-sum 5% bonus payments for professional

[1] Centers for Medicare and Medicaid Services (Aug. 30, 2022). "Medicare Shared Savings Program Saves Medicare More Than $1.6 Billion in 2021 and Continues to Deliver High-quality Care." https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-saves-medicare-more-16-billion-2021-and-continues-deliver-high

services; exemption from MIPS reporting requirements and payment adjustments; and higher base-payment updates, beginning in 2026. This 5% incentive provides crucial resources to support non-fee-for-service programs, including meal delivery programs, transportation services, and digital tools and care coordinators, each of which promote population health. However, MACRA statute only provides advanced APM bonuses through the CY 2024 payment period. This means that providers will not be able to qualify for incentives after the end of 2022, since payments are made two years after performance periods.

Because participation in the advanced APM program has fallen short of initial projections, spending on advanced APM bonuses has fallen well short of the amount the Congressional Budget Office projected when MACRA was originally scored. Repurposing the spending shortfall for APM bonuses in future years will serve to accelerate our shared goal of increasing APM adoption.

Support Investment in Resources for Rural Hospitals

Congress should encourage CMS to continue its investment of resources and infrastructure to support rural hospitals' transition to APMs. According to a Government Accountability Office report, only 12% of eligible rural providers in 2019 participated in the advanced APM program; of those that participated, just 6% of rural providers participated in two or more advanced APMs, compared to 11% of those not in rural areas.[2] This is because these models are often not designed in ways that allows broad rural participation. For example, rural hospitals often do not meet minimums for the number of patients required to participate; similarly, rural hospitals' financial situations might not allow them to take on more risk. Additionally, rural hospitals may not have sufficient staff to comply with reporting requirements that were designed with larger institutions in mind.

AHA supports continued efforts to better support rural hospitals' migration to advanced APM models. In particular, the AHA has since 2021 supported the establishment of a Rural Design Center within the Centers for Medicare and Medicaid Innovation (CMMI), which would focus on smaller-scale initiatives to meet rural communities' needs and encourage participation of rural hospitals and facility types. In the time since AHA first made this recommendation to CMMI, it has yet to be implemented.

Still, a Rural Design Center would help develop and increase the number of new rural-focused CMMI demonstrations, expand existing rural demonstrations and create separate rural tracks within new or existing CMMI models. For example, CMMI in August 2020 released a new Community Health Access and Rural Transformation (CHART) payment model for rural hospitals that provided increased financial stability

[2] US Government Accountability Office (November 2021). "Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas." https://www.gao.gov/assets/gao-22-104618.pdf

through upfront payments. This model is an example of the type of model that the Design Center might develop or expand on a broader scale. This would also provide an opportunity for rural hospitals to innovate at the local level. For instance, rural hospitals could benefit from upfront, predictable, and sufficient payments to allow providers to build their infrastructure and provide the capability to redesign care delivery, similar to what is currently being achieved through the Pennsylvania Rural Health Model.

Medical Home Clinician Limit

Congress should also encourage CMS to enable greater participation in advanced APMs from hospitals and health systems by broadening its definitions for Medical Home qualification criteria. Per the MACRA statute, certain medical homes can qualify as advanced APMs. Specifically, CMS adopted relaxed financial risk standards for medical homes to qualify as advanced APMs, but limited availability to APM entities owned and operated by organizations with 50 or fewer clinicians. The AHA supports CMS's proposal to revise the advanced APM medical home clinician limit to apply to the entity level (not parent-organization level), but remain concerned that the limit severely constrains the ability for hospital or health system-affiliated clinicians and groups to benefit from medical home participation. We urge CMS to explore ways of enabling more hospital- and health system-affiliated clinicians to enter the advanced APM track through medical home participation.

MIPS

From a regulatory perspective, the AHA has urged CMS to implement MIPS in a way that focuses on high-priority quality issues; is gradual and flexible; measures providers accurately and fairly; minimizes unnecessary data collection and reporting burdens; and fosters collaboration across the silos of the health care delivery system. CMS has adopted many policies to align with these principles, including its gradual increases to reporting periods, data standards and performance thresholds for receiving positive or negative payment adjustments. CMS has also implemented a facility-based measurement approach and removed some outmoded quality measures.

However, the AHA remains concerned about the direction of the MIPS Value Pathways (MVPs) program that CMS intends as an eventual replacement for its current MIPS approach. We also have concerns about several of CMS's proposed changes to the MIPS reporting requirements and scoring approaches outlined in the Physician Fee Schedule calendar year 2023 proposed rule.

MIPS Value Pathways

CMS has indicated that MVPs are intended to align and reduce reporting requirements across the four MIPS performance categories. MVPs would build over time and organize the reporting requirements for each MIPS category around specific specialties, treatments or other priorities. However, numerous questions remain about whether CMS can construct enough MVPs that are applicable to the more than one million

eligible clinicians participating in the MIPS, and whether MVPs would facilitate equitable comparisons of performance across clinical and group types and specialties. The measures currently available in the MIPS program have enabled CMS to propose a modest expansion of the number of available MVPs, starting with the CY 2023 reporting period, during which CMS would add five new MVPs related to cancer care, kidney health, episodic neurological conditions, neurodegenerative conditions and promoting wellness. While the AHA supports this proposal, it is not clear how many more MVPs CMS can add to the program without significantly adding to the program's measure count. Given CMS's correct focus on implementing "Meaningful Measures" in its programs, it would seem misguided to add measures just for the sake of having enough of them to create an MVP.

Congress should encourage CMS not to set a "date certain" for mandating participation in MVPs unless and until CMS can demonstrate that MVPs are feasible for broad ranges of clinicians, while also resulting in fair performance comparisons for all who participate in the MIPS. Congress could help foster the important foundational work for CMS to address these issues by asking the agency to construct several "prototype" MVPs that would each cover a wide range of clinicians, determine how many clinicians it could potentially assign to each, and obtain clinician input on whether the measures in those MVPs would align with their clinical practice. This would also enable CMS to look at the performance distributions across MVP models to determine whether any specialty types or group types score any worse than others.

We also ask that Congress be attentive to the potential administrative burdens that could be introduced by MVPs by asking CMS to produce burden estimates. The AHA is especially concerned by CMS's proposal in the CY 2023 proposed Physician Fee Schedule that would mandate multi-specialty practices wishing to participate in MVPs to form subgroups within single tax ID numbers, starting in CY 2026. While this is an essential option for multi-specialty practices, mandating subgroup classifications could increase the reporting burden and could disincentivize participation. The AHA has urged CMS to reconsider its policy of mandating subgroup formation for multi-specialty practices participating in MVPs.

Improve Measures in MIPS Cost Category

The AHA believes that rigorously designed, clinically relevant cost measures can help provide insights into the value of care that clinicians deliver. At the same time, we have long been concerned with these measures' limited actionability, extraordinary complexity, questionable reliability and rushed implementation.

For example, CMS uses two overall cost measures – Medicare Spending per Beneficiary (MSPB) for MIPS and total cost per capital – that measure performance through a very limited "line of sight" on clinician actions. The measures do not reflect the performance of just clinicians or group practices. Rather, the measures attribute all of the Medicare Parts A and B costs for beneficiaries during a defined episode (three days

prior to 30 days after an inpatient admission for MSPB, and a full year for total cost per capita). These costs, however, reflect the actions of a multitude of health care entities, including hospitals, physicians, post-acute providers, etc. The ability for any clinician or group to influence overall measure performance will vary significantly depending on local market factors, including the prevalence of clinically integrated networks. We urge CMS to re-assess the impact of these factors on MSPB.

CMS has also made changes to the overall cost measures that may have degraded their reliability and accuracy. For example, the MSPB for MIPS measure once had a minimum case threshold of 125 cases because CMS's analyses suggested that this is the number of cases that was necessary to deliver statistically reliable results. Yet, for the CY 2023 program year, the minimum case threshold is only 35 cases. We worry that these measure changes will result in rewards or penalties based on differences in patient population or statistical noise, rather than real performance differences.

Lastly, CMS has implemented episode-based cost measures that include only the items and services related to episodes of care for particular treatments or conditions. This measurement approach can result in more clinically coherent sets of information about cost. However, this approach also necessitates the use of algorithms for identifying costs relevant to an episode, and a multi-step approach for attributing measure performance. This methodology adds necessary rigor, but also complexity, so much so that many members have told us they find the measure difficult to use for improvement purposes. Even more troublingly, these episode-based measures have been added to the MIPS program without the benefit of an endorsement review by the National Quality Forum (NQF), which would give the field more transparency around whether they are accurate, reliable and feasible.

Congress should encourage CMS to take steps to improve the cost measures described above. This includes pursuing National Quality Forum (NQF) endorsement of all cost measures used in the MIPS; re-examining the attribution methodologies; and incorporating risk adjustment for social risk factors where necessary and appropriate.

Enhancing Risk Adjustment

Congress should encourage CMS to continue evaluating and refining its approach to accounting for both clinical and social risk factors in measuring performance outcomes. The AHA applauds the important steps CMS has taken in recent years to account for the role of social risk factors in influencing clinician performance. The agency adopted a "complex patient bonus" in the MIPS in 2018, in which clinicians received up to five bonus points on their MIPS Final Scores based on a Medicare claims-derived proxy for patient complexity (Hierarchical Condition Categories, or HCCs), as well as the number of Medicare and Medicaid dually eligible patients that a clinician or group treats. CMS further refined this approach in 2021 by increasing the bonus to 10 points and updating its calculation approach to more effectively target bonuses to clinicians and groups serving the highest proportions of patients with medical and social risks.

At the same time, the science of whether and how to account for social risk factors in measurement will continue to evolve. For example, while dual eligibility is an established proxy for social risk, there are others, such as income and education, that may be more accurate adjusters for particular measures. In addition, as the use of digital quality measures (dQMs) that draw data from electronic health records (EHRs) continues to spread, there may be opportunities to introduce more precise clinical data into the risk adjustment models for outcome measures. CMS should continue to closely evaluate the results of its complex patient adjustment and remain engaged with stakeholders on optimal approaches to risk adjustment.

Ensuring Feasibility of Promoting Interoperability Requirements

Congress should encourage CMS to provide flexibility for the Promoting Interoperability category requirements that are tied to the use of systems over which clinicians may have limited control. As part of the CY 2023 PFS proposed rule, CMS expanded the requirement for Prescription Drug Monitoring Programs (PDMPs) to include schedule II, III and IV drugs. Yet, over the past few years, we have heard many reports from our members that accessing their state PDMPs is time-consuming for clinicians, often requiring that they exit the hospital's medical record and then spend several minutes trying to connect with, and query, the PDMP because the state's technology is outdated.

We urge CMS to recognize that this is not the time to put more burden on clinicians, even for the important task of consulting the PDMPs, and instead provide for enforcement discretion or a waiver until states have improved their technology to enable easy inquiries. Similarly, AHA has asked CMS for flexibility and coordination of the changes to its Public Health and Clinical Information Data Exchange to ensure the public health agencies are capable of receiving the data. The Coronavirus Aid, Relief, and Economic Security (CARES) Act provided funding to Centers for Disease Control and Prevention (CDC) to disseminate to public health agencies to improve their technology systems' ability to enable receiving significant public health data from hospitals and other providers of care.

We believe the CDC is in the process of disseminating funds to state and local public health departments to update their critical information systems and become capable of receiving hospitals' information, but this will take time. Congress should encourage CMS to consult with the CDC around this funding and the anticipated implementation schedule, and to delay updating scoring categories until clinicians have the opportunity to work with their public health agencies that are able to receive their data.

Evolving MIPS in the Future

In addition to the specific regulatory areas cited above, the AHA believes that both future statutory and regulatory changes should be guided by data, experience and input from the field. As with any significant policy change, the QPP and MIPS will need ongoing refinements to ensure it meets its goals, which is why Congress used the

Bipartisan Budget Act of 2018 to make several welcome technical amendments to the MIPS. Such technical amendments have provided CMS with more time to increase the weight of the MIPS cost category and apply payment adjustments to only covered professional services.

These changes give providers and CMS greater flexibility and improve the program's fairness. Some stakeholders also have also urged a complete overhaul and replacement of the MIPS program. Most notably, the Medicare Payment Advisory Commission (MedPAC) has urged that the MIPS program be replaced by a Voluntary Value Program (VVP) that would withhold at least 2% of clinician payment unless clinicians either joined an advanced APM or agreed to be measured as part of a group of clinicians on measures of "population-based outcome measures" (e.g., mortality, readmissions, hospital admissions). However, the AHA believes the VVP program would be impractical to implement, and would be overly reliant on billing data that often does not fully and accurately reflect clinician performance. For additional details on our concerns about the VVP, please see AHA's March 2018 statement to the House Ways and Means Health Subcommittee.

Medicare Shared Savings Program (MSSP)

Our members remain enthusiastic about the MSSP as one pathway to advance their ongoing efforts to transform care delivery through improved care coordination and financial accountability. The AHA appreciates CMS's efforts, including in the CY 2023 proposed Physician Fee Schedule, to reduce barriers to entry; provide more gradual transitions to risk; and expand eligibility for incentives to better support organizations caring for underserved patient populations. We encourage continued regulatory efforts to meet these goals, as ultimately this will increase participation in MSSP and help further advance our collective goal to transition to value.

Advance Investment Payments (AIPs) for Certain ACOs
Congress should encourage CMS to expand AIPs for all ACOs working to combat health inequities. The AHA supports efforts by CMS to provide upfront financial support for certain ACOs to use for infrastructure investment. This will particularly help rural and underserved communities, which may find it challenging to cover initial up-front capital expenditures. For small and rural providers, such expenditures include upfront costs related to hiring additional staff, developing new care management strategies and performing analysis to estimate the provider's performance. That said, the AHA believes that AIPs should be available to all ACOs working to combat health inequities.

Specifically, we share CMS's commitment to advancing health equity and ensuring access to high-quality, high-value care. By providing adequate funding for all ACOs to address health-related social needs and reduce disparities, we can advance our shared goal of achieving equitable health outcomes for all.

Recommend Elimination of Low-Revenue/High-Revenue Qualifying Criteria
Congress should also urge CMS to eliminate its designation of ACOs as either low- or high-revenue. The agency has used this label as a proxy measure to, for example, determine if an organization is supporting underserved populations and/or if the organization is physician led in order to qualify for AIPs. Yet, there is no valid reason to conclude that this delineation, which measures an ACO's amount of "captured" revenue, is an accurate or appropriate predictor of whether it treats an underserved region. In fact, analysis suggests that Critical Access Hospitals, federally qualified health centers and rural health centers are predominantly classified as high-revenue. Further, both low- and high-revenue ACOs are working to address health equity as part of their care transformation work; assistance investing in these efforts would help across the board.

Gradual transition to Performance-Based Risk
We request continued support for the gradual transition to performance-based risk. The AHA strongly supports CMS's proposals for more gradual transitions to risk for certain ACOs. For example, allowing ACOs inexperienced with performance-based risk to participate in one-sided shared savings models for the duration of one five-year agreement and allowing ACOs to remain in Level E of the BASIC track indefinitely will provide more time for ACOs to invest in necessary infrastructure and adjust workflows. More gradual glide paths to risk will help increase participation, experience and shared savings under the program by empowering ACOs to maximize their contribution to patient care.

We appreciate your consideration of these issues and the opportunity to provide comment. We are committed to supporting the movement to value-based care. We look forward to working with you on these recommendations to support greater participation and enhanced efficacy of MACRA and its programs.

Sincerely,

/s/

Stacey Hughes
Executive Vice President, Government Relations and Public Policy
American Hospital Association