American Hospital Association™
Advancing Health in America

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June 22, 2023

The Honorable H. Morgan Griffith
Chair
U.S. House of Representatives
Oversight and Investigations
Subcommittee
Energy and Commerce Committee
Washington, DC 20515

The Honorable Kathy Castor
Ranking Member
U.S. House of Representatives
Oversight and Investigations
Subcommittee
Energy and Commerce Committee
Washington, DC 20515

Re: Energy and Commerce Subcommittee Hearing on MACRA Implementation and Challenges

Dear Chair Griffith and Ranking Member Castor:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations and 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) writes to thank you for holding an oversight hearing today on the Medicare Access and CHIP Reauthorization Act (MACRA) and the challenges that remain for patients and doctors. We remain committed to working with Congress on finding opportunities to increase the efficacy of and participation in the programs authorized by MACRA and transitioning our health care system from volume to value.

The adoption of the bipartisan MACRA in 2015 was an important step in shifting the physician payment model from fee-for-service payment to reimbursement based on quality and value metrics by replacing the historical Sustainable Growth Rate (SGR) with the Quality Payment Program (QPP). The QPP 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). As hospitals and health systems continue to deal with unprecedented strain due to rising inflation, massive staffing shortages, and a variety of other factors, it is more crucial than ever to provide the field with financial stability and further the transition to value-based care.

In the fall of 2022, the AHA submitted feedback on a Request for Information (RFI), led by Reps. Ami Bera, D-Calif., and Larry Bucshon, R-Ind., on ways to stabilize the

Medicare payment system. In our response, the AHA provided Congress with statutory and regulatory options that could be taken in order to further support flexible implementation and widespread adoption of value-based and alternative payment models. These proposals, such as additional investment in resources for rural providers and updates to the physician fee schedule to support more inclusive definitions and updated metric methodologies, would all encourage higher rates of APM adoption among hospitals and health systems.

Below are highlights from our recommendations that the AHA included in its response, as well as additional feedback:

Advanced APMs

- ***Extension of Advanced APM Incentive Payments.*** We appreciate Congress taking action through a provision in the Consolidated Appropriations Act of 2023 to extend the Advanced APM Incentive Payments at 3.5% for the Calendar Year (CY) 2025 payment period. While lower than the current 5% incentive payment rate, the 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. 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 the Centers for Medicare & Medicaid Services (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.[1] These models are often not designed in ways that allows broad rural participation, and the AHA supports continued efforts to better support rural hospitals' migration to advanced APM models. In particular, the AHA since 2021 has supported the establishment of a Rural Design Center within the Center for Medicare and Medicaid Innovation (CMMI), which would focus on smaller-scale initiatives to meet rural communities' needs and encourage participation of rural hospitals

[1] 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

and facility types. 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.

Merit-based Incentive Payment System (MIPS)

- ***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. The cost measures currently in place have flawed metrics in evaluating performance and may result in rewards or penalties based on differences in patient population or statistical noise. Congress should encourage CMS to take steps to improve these cost measures by pursuing consensus-based entity endorsement of all cost measures used in the MIPS; re-examining the attribution methodologies; and accounting for the influence of social risk factors beyond providers' control in calculating performance where necessary and appropriate.

Medicare Shared Savings Program (MSSP)

- ***Promote Gradual Transition to Performance-Based Risk.*** We request continued support for the gradual transition to performance-based risk. The AHA strongly supports CMS' proposals for more gradual transitions to risk for certain Accountable Care Organizations (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.

- ***Eliminate Low-Revenue/High-Revenue Qualifying Criteria.*** Congress also should 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 Advance Investment Payments. 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.

Medicare Site-neutral Payment Reductions

One additional factor that has impacted transition to value-based care has been the longstanding challenges with insufficient reimbursement. Hospitals, health systems and private practices have experienced negative operating margins, posing challenges to migrating to APMs since organizations have not had resources to support infrastructure investments (like staffing, analytics software, etc.). Site-neutral policies only exacerbated challenges with reimbursement rates that have been insufficient to cover rising inflation and increasing input costs.

The AHA strongly opposes additional site-neutral payment cuts, which threaten access to care. Existing site-neutral payment cuts have already had a significantly negative impact on the financial sustainability of hospitals and health systems and have contributed to Medicare's chronic failure to cover the cost of caring for its beneficiaries.

Site-neutral policies are based on the flawed assumption that PFS payment rates are sustainable rates for physicians. However, the truth is much different. According to the American Medical Association, "Medicare physician payment has effectively been cut 26%, adjusted for inflation, from 2001–2023…The discrepancy between what it costs to run a physician practice and actual payment combined with the administrative and financial burden of participating in Medicare is encouraging market consolidation and threatens to drive physicians out of rural and underserved areas."[2]

Additionally, physicians are increasingly turning to hospitals, health systems and other organizations for financial security, and to focus more on clinical care and less on the administrative burdens and cost concerns of managing their own practice.[3] The administrative and regulatory burden associated with public and private insurer policies and practices, coupled with inadequate reimbursement rates, are important barriers to operating an independent physician practice. A recent survey of physicians conducted by Morning Consult on behalf of the AHA found that over 90% of physicians think it has become more financially and administratively difficult to operate a practice and that 84% of employed physicians reported that the administrative burden from payers had an impact on their employment decision.[4]

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[2] https://www.ama-assn.org/practice-management/medicare-medicaid/advocacy-action-leading-charge-reform-medicare-pay
[3] https://www.merritthawkins.com/uploadedFiles/merritt-hawkins-2021-resident-survey.pdf
[4] https://www.aha.org/fact-sheets/2023-06-07-fact-sheet-examining-real-factors-driving-physician-practice-acquisition

These factors are creating unworkable environments forcing physicians to prioritize administrative duties over caring for patients. The result is increased burnout among physicians. There are no signs of this stopping anytime soon.[5] Physicians are searching for alternative practice settings that reduce these burdens and provide adequate reimbursement, while allowing them to focus on patient care. Hospitals and health systems are a natural fit to help physicians alleviate many of these burdens.

- ***Conversion Factor Updates.*** As mentioned above, physician reimbursement updates have not accounted for rising inflation or increasing input costs (like supply chain disruptions and workforce shortages). The widening gap between physician reimbursement rates and increases in the Medicare economic index (which is the CMS proxy measure for inflation) puts some numbers to this crisis, which poses significant threats to patient access and provider financial stability, particularly for safety-net providers.

  The current conversion factor updates scheduled in MACRA may be too little too late since they are scheduled to begin in 2026, and will only result in a .75% conversion factor update for qualifying advanced APM participants and .25% for all other providers. While the one-time conversion factor updates provided in the Consolidated Appropriations Act of 2022 and 2023 have provided some needed relief in the interim, we would encourage more sustainable, real time approaches to updating the conversion factors in pace with inflation. Annual conversion factor updates should be made to reflect changes in input costs and inflation. This will support physicians' ability to transition to APMs.

Conclusion

The AHA appreciates the Energy and Commerce Oversight and Investigations Subcommittee recognizing the need for large scale reform to further the transition to value-based care. We look forward to working with you on ways to support greater participation and enhanced efficacy of MACRA on behalf of our patients and their communities.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President, Advocacy and Political Affairs

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[5] https://www.uhcprovider.com/en/resource-library/news/2023/new-requirements-gastroenterology-services.html