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Advancing Health in America

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Statement

of the

American Hospital Association

for the

Committee on Ways and Means

Subcommittee on Health

of the

U.S. House of Representatives

"Improving Value-Based Care for Patients and Providers"

June 26, 2024

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 provide feedback on the transition to value-based care.

THE ROLE OF ALTERNATIVE PAYMENT MODELS IN VALUE-BASED CARE

Our members support the U.S. health care system moving toward the provision of more outcomes-based, coordinated care and are continuing to redesign delivery systems to increase value and better serve patients. Over the last 14 years, many of our hospital and health system members have participated in a variety of alternative payment models (APMs).

While the movement to value holds tremendous promise, the transition has been slower than anticipated and more needs to be done to drive long-term system transformations.

There are principles that we believe should guide the development of APM design to make participation more attractive for potential participants. These include:

- **Appropriate On-ramp and Glidepath to Risk.** Model participants should have an adequate on-ramp and glidepath to transition to risk. They must have adequate time to implement care delivery changes (integrating new staff, changing clinical workflows, implementing new analytics tools, etc.) and review data prior to initiating the program.
- **Adequate Risk Adjustment.** Models should include adequate risk adjustment methodologies to account for social needs and clinical complexity. This will ensure models do not inappropriately penalize participants treating the sickest, most complicated and underserved patients.
- **Voluntary Participation and Flexible Design.** Model designs should be flexible, incorporating features such as voluntary participation, the ability to choose individual clinical episodes, the ability to add components/waivers and options for participants to leave the model(s).
- **Balanced Risk Versus Reward.** Models should also balance the risk versus reward in a way that encourages providers to take on additional risk but does not penalize those that need additional time and experience before they are able to do so. A glidepath approach should be implemented, gradually migrating from upside only to downside risk.
- **Guardrails to Ensure Hospitals Do Not Compete Against Their Own Best Performance.** Models should provide guardrails to ensure that participants are not penalized over time when they achieve optimal cost savings and outcomes performance. Participants must have incentives to remain in models for the long-term.
- **Resources to Support Initial Investment.** Upfront investment incentives should be provided to support organizations in their transition to value-based payment. For example, to be successful in such models, hospitals, health systems and provider groups must invest in additional staffing and infrastructure to support care delivery redesign and outcomes tracking.
- **Transparency.** Models' methodology, data and design elements should be transparently shared with all potential participants. Proposed changes should be vetted with stakeholders.
- **Adequate Model Duration.** Models should be long enough in duration to truly support care delivery transformation and assess the impact on outcomes. Historically, models have been too short and/or have had multiple, significant design changes even within the designated duration, making it difficult for participants to self-evaluate and change course when necessary.
- **Timely Availability of Data.** Model participants should have readily available, timely access to data about their patient populations. We would encourage the dedication of resources from the Centers for Medicare & Medicaid Services (CMS)

(staff and technology) to provide program participants with more complete data as close to real-time as possible.

- **Waivers to Address Barriers to Clinical Integration and Care Coordination.** This entails waiving Medicare program regulations that frequently inhibit care coordination and work against participants' efforts to ensure that care is provided in the right place at the right time.

POLICIES TO SUPPORT HOSPITAL TRANSITIONS TO VALUE-BASED CARE

Extension of Advanced APM Incentive Payments. The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was also intended to support the transition to value-based care. MACRA provided advanced incentive payments (5%) for providers participating in advanced APMs through 2024. These payments were designed to assist with the provision of non-fee-for-service programs like meal delivery programs, transportation services, digital tools and care coordinators which promote population health, among other services.

However, MACRA statute only provided the advanced APM bonuses through the calendar year (CY) 2024 payment period. We appreciate Congress acting through a provision in the Consolidated Appropriations Act (CAA) of 2023 to extend the advanced APM incentive payments at 3.5% for the CY 2025 payment period and again in the CAA of 2024 to extend through 2026 at 1.88%.

While lower than the current 5% incentive payment rate, the incentive provides crucial resources. 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. **We urge the extension of these incentive payments.**

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 to qualify for advance investment payments. Yet, there is no valid reason to conclude that this delineation, which measures an accountable care organization's (ACO) 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. **We urge the removal of problematic high/low revenue thresholds that preclude rural and critical access hospitals from obtaining necessary resources for infrastructure investment.**

Support Investment in Resources for Rural Hospitals. Congress should encourage CMS to continue its resources and infrastructure investment 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. These models are often not designed in ways that allow 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 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.**

We support the Value in Health Care Act (H.R. 5013/S. 3503), which would extend incentive payments, remove revenue distinctions and improve financial benchmarks to ensure participants are not penalized for success.

RECENT CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMMI) MODELS

Proposed Transforming Episode Accountability Model. On April 10, as part of the inpatient prospective payment system (PPS) proposed rule, the CMMI proposed a new mandatory payment model — Transforming Episode Accountability Model (TEAM) — that would bundle payment to acute care hospitals for five types of surgical episode categories: coronary artery bypass graft, lower extremity joint replacement, major bowel procedure, surgical hip/femur fracture treatment and spinal fusion. It would make acute care hospitals responsible for the quality and cost of all services provided during select surgical episodes, from the date of inpatient admission or outpatient procedure through 30 days post-discharge.

The AHA has significant concerns with the TEAM payment model. We are supportive of the Department of Health and Human Services Secretary's goal of moving toward more accountable, coordinated care through new APMs. However, CMS is proposing to mandate a model that has significant design flaws, and as proposed places too much risk on providers with too little opportunity for reward in the form of shared savings, especially considering the significant upfront investments required. If CMS cannot make extensive changes to the model, it should not implement it at this time. To do so would make TEAM no more than a thinly disguised payment cut, as it fails to provide hospitals a fair opportunity to achieve enough savings to garner a reconciliation payment.

The proposal does not align with the principles we outlined above. For example, we have previously commented on the necessity for waivers to support care coordination, more gradual glidepaths to two-sided risk and reasonable discount factors to ensure

financial viability. If anything, TEAM is a step backward with fewer waivers, shorter timelines to assume downside risk and more aggressive discount factors that make cost savings more challenging.

Moreover, the tremendous scope of this rule and its aggressive 60-day comment period made it challenging to fully evaluate and analyze the proposal and its significant impact on hospitals and health systems. The five types of surgical procedures proposed for inclusion in TEAM comprise over 11% of inpatient PPS payments in 2023 — a staggering amount that does not even include the outpatient payments that would be at risk as part of the model. While the AHA worked closely with our hospital and health system members to assess the potential impact of TEAM on the important work they do in caring for their patients and communities, the incredibly short comment period severely hampered our ability to provide comprehensive comments.

We strongly recommend that CMS make TEAM voluntary, lower the 3% discount factor and make several changes to problematic design elements.

Proposed Increasing Organ Transplant Access Model. Just four weeks after TEAM was proposed, CMS proposed another mandatory payment model for kidney transplants. The Increasing Organ Transplant Access (IOTA) model would test whether performance-based incentives or penalties for participating transplant hospitals would increase access to kidney transplants for patients with end-stage renal disease while preserving or enhancing quality of care, improving equitable access to kidney transplant care and reducing Medicare expenditures. The model would run for six years, beginning Jan. 1, 2025. Hospitals eligible for participation would include non-pediatric transplant facilities conducting at least 11 kidney transplants during a three-year baseline period. It is anticipated that 90 hospitals would be required to participate.

While we appreciate CMMI's goals of increasing access to kidney transplants, we are again left questioning the model design elements and are concerned that the model as written may have unintended consequences by focusing so heavily on volume (namely sub-par matches). Also, as mentioned above, implementation of complex payment models requires significant time, resources and staffing on the part of hospital participants. But CMMI has proposed a start date of Jan. 1, 2025. Given the transformation that is already occurring nationally under provisions of the Organ Procurement and Transplantation Network Act, this aggressive timeline is untenable. Additionally, we are concerned that CMMI is again proposing mandatory participation. As mentioned in our principles, it is critical that organizations can assess whether models are appropriate to best serve the needs of their patients and communities. Therefore, participation should be voluntary.

CONCLUSION

The APM model design principles we outlined above would support more organizations' abilities to provide accountable and coordinated care. The AHA urges Congress to

extend APM incentive payments, for CMS to remove problematic high- and low-revenue thresholds that preclude rural and critical access hospitals from obtaining necessary resources for infrastructure investment, and for CMMI to make models such as TEAM and IOTA voluntary.

The AHA appreciates your efforts to examine these issues, and we look forward to working with you.