American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

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The Honorable Ron Wyden
Chairman
Committee on Finance
United States Senate
221 Dirksen Senate Office Building
Washington, DC 20002

The Honorable Mike Crapo
Ranking Member
Committee on Finance
United States Senate
239 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of AHA's 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) writes to you to provide comment on the Senate Finance Committee white paper on Bolstering Chronic Care through Physician Payment, Current Challenges and Policy Options in Medicare Part B.

We appreciate that the Senate Finance Committee has highlighted some of the pressing challenges confronting doctors reimbursed under the physician fee schedule (PFS). Indeed, current reimbursement for physicians is woefully inadequate and fails to account for inflation, which continues to outpace updates to reimbursement for services covered under the physician fee schedule. The latest Medicare Trustee's Report indicates that physician reimbursement has dropped over 20% over the last 20 years when accounting for inflation. In addition, there is a widening gap between the conversion factor updates and Medicare Economic Index (a proxy measure for physician cost inflation).

These reimbursement shortfalls to Medicare physician payment have come at a time of other headwinds. Hospitals and health systems are currently facing a national staffing emergency that could jeopardize access to high-quality, equitable care for patients and the communities they serve. Physician shortages are projected to exceed 86,000 physicians by 2036 according to the Association of American Medical Colleges. We have also seen how increased administrative burden is contributing to physician burnout

and clinicians leaving the field. The aging beneficiary population is also increasing demand for services, while the supply of clinicians continue to decline. We appreciate the actions Congress has taken to support physicians by passing one-time adjustments to partially offset decreases to conversion factor. However, more sustainable solutions are needed to ensure that updates to the PFS more accurately reflect the cost of delivering services.

Considering these challenges, the AHA supports the following legislative and regulatory changes to ensure more sustainable physician reimbursement and to facilitate transition to value-based care.

Addressing Payment Update Adequacy and Sustainability

Conversion Factor Updates. Portions of the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) were intended to fix some of the legacy issues with the historical sustainable growth rate (SGR), namely by replacing updates to the conversion factor which were tied to gross domestic product with updates that more accurately covered rising health care input costs through the Medicare Economic Index (MEI). However, inflation (as measured by the MEI) is growing faster than increases in PFS rates.

From 2015-2019, MACRA provided a 0.5% increase in the conversion factor. However, starting in 2020 through 2025 there was a gap where MACRA programmed a 0% update to the conversion factor. The lack of a preset update combined with budget-neutral decrements has resulted in negative conversion factor updates and continued decreases in reimbursement despite rising input costs. This is because there is a compounding effect, whereby the cuts in one year mean that cuts in future years are already based on an artificially negative baseline and reimbursement exponentially spirals downward. To partially soften the cuts from the PFS after budget neutrality adjustments, Congress has acted to increase the conversion factor through one-time adjustments. For example, the Consolidated Appropriations Act (CAA) of 2023 provided partial relief for 2024 physician reimbursement rates through a one-time 1.25% increase. Even with the 1.25% adjustment, the conversion factor was still cut by 3.4% — meaning that reimbursement rates were still scheduled for a -3.4% reduction despite the one-time congressional add-on. As such, Congress again acted to increase the conversion factor by an additional 1.68%. This uncertainty has contributed to financial instability.

The current conversion factor updates scheduled in MACRA are insufficient since they are scheduled to begin in 2026 and will only result in a 0.75% conversion factor update for qualifying advanced Alternative Payment Model (APM) participants and 0.25% for all other providers. This will be too little too late since again these will only partially offset the decrements that have occurred over the last 20 years. While the one-time conversion factor updates provided in the CCAs of 2022, 2023 and 2024 have provided

needed relief in the interim, **we 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 outside of budget neutrality.**

Incentivizing Participation in Alternative Payment Models

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 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.

Programmatic Design Principles. There are principles that we believe should guide the development of APM design that would 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 can do so. A glidepath approach should be implemented, gradually migrating from upside only to downside risk.
- Guardrails Ensure Long-term Performance Gains. Models should provide guardrails to ensure that participants do not have to compete against their own best performance and 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.

Extension of Advanced APM Incentive Payments. 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 CCA 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 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. 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.**

In conclusion, to support the transition to value-based payment, the AHA urges Congress to extend APM incentive payments and for CMS to remove problematic high- and low-revenue thresholds that preclude rural and critical access hospitals from obtaining necessary resources for infrastructure investment. **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 their success.**

Reducing Physician Reporting Burden Related to Merit-based Incentive Payment System

Improve Measures in Merit-based Incentive Payment System (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.**

Chronic Care Benefits in Fee-for-service

Waiving Cost-sharing for Chronic Care Management. We endorse efforts to remove the patient cost-sharing obligations from the Chronic Care Management (CCM) code. Millions of chronically ill Medicare beneficiaries stand to benefit from the care coordination and care management services the code supports.
Because CCM is a critical part of coordinated care, Medicare began reimbursing clinicians for primarily non-face-to-face chronic care management under a separate code in the 2015 Medicare PFS to manage chronic conditions and improve patients' health more effectively. Providers and care managers report many positive outcomes for beneficiaries who receive CCM services, including improved patient satisfaction and adherence to recommended therapies, improved clinician efficiency, and decreased hospitalizations and emergency department visits.
However, creating a separate billable code created a beneficiary cost-sharing obligation for care management services. Under current policy, Medicare beneficiaries are subject to a 20% coinsurance requirement to receive the service. This cost-sharing requirement creates a barrier to care, as beneficiaries are not accustomed to cost-sharing for care management services. The latest data reveals that only 4% of Medicare beneficiaries potentially eligible for CCM received these services. That amounts to 882,000 out of a potential pool of 22.5 million eligible CCM beneficiaries. **Removing the coinsurance payment requirement would facilitate more comprehensive management of chronic care conditions and improve the health of Medicare patients. Additionally, removing patient coinsurance may facilitate greater care coordination for underserved patient populations.**

Ensuring Beneficiaries' Continued Access to Telehealth

While we recognize that the committee did not have specific questions for consideration regarding continued access to telehealth, we echo the concerns expressed regarding a coverage cliff risk that could result if Congress does not act to extend critical waivers before the end of the year.
The expansion of telehealth services during the public health emergency has transformed care delivery, expanded access for millions of Americans and increased convenience in caring for patients, especially those with transportation or mobility limitations. Given current health care challenges, including major clinician shortages, telehealth holds tremendous potential to leverage geographically dispersed provider

capacity to support patient demand. **We urge Congress to make these key telehealth flexibilities permanent before they expire on Dec. 31, 2024, and extend waivers for the hospital-at-home program.**

Specifically, we support the following.

- Permanently eliminating originating- and geographic-site restrictions, thus allowing telehealth visits to occur at any site where the patient is located, including urban areas and the patient's home.
- Permanently eliminating in-person visit requirements for tele-behavioral health, which would ensure patients do not need an in-person visit before initiating virtual treatment.
- Permanently removing distant site restrictions on federally qualified health centers and rural health clinics, which would ensure that they can continue to provide telehealth services.
- Permanently allowing payment and coverage for audio-only telehealth services.
- Permanently expanding eligible telehealth provider types to include physical therapists, occupational therapists, speech-language pathologists and audiologists.

Conclusion

We appreciate the committee's attention to finding concrete pathways to update the Medicare physician payment system. We look forward to continuing working with you on this important initiative.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President
Advocacy and Political Affairs