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Statement

of the

American Hospital Association

for the

Committee on Energy and Commerce

Subcommittee on Health

of the

U.S. House of Representatives

"Checking-In on CMMI: Assessing the Transition to Value-Based Care"

June 13, 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. The AHA appreciates the Centers for Medicare & Medicaid Services' (CMS) continued efforts to develop innovative payment models to reward providers based on outcomes rather than patient volume.

Over the last 14 years, many of our hospital and health system members have participated in a variety of alternative payment models (APMs) developed by the Center for Medicare and Medicaid Innovation (CMMI). Some APMs have generated net savings for taxpayers while maintaining quality of care for patients.

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. CMMI plays a critical role in ensuring that hospitals and providers are set up for success in the various models they deploy. But some of the CMMI models were designed with requirements that made implementation exceedingly difficult and success even more so.

There are principles that we believe should guide the development of APM design. 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.

To ensure that these and other practical considerations are appropriately included in CMMI models, we believe the agency would benefit enormously from consulting an

advisory group of hospital and health system leaders who are managing or have managed the kind of organizations that would be part of the models CMS is trying to build.

TEAM PROPOSED PAYMENT 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.

INCREASING ORGAN TRANSPLANT ACCESS PROPOSED 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

Again, the AHA supports the health care system moving toward the provision of more accountable, coordinated care. We recognize the critical role CMMI plays in advancing innovative payment models. We have recommended principles that should guide the development of APM model design and are concerned that recent model proposals such as TEAM and IOTA are steps backwards. The AHA appreciates your efforts to examine these issues, and we look forward to working with you.