American Hospital Association™
Advancing Health in America

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The Honorable Sheldon Whitehouse
U.S. Senate
530 Hart Senate Office Building
Washington, DC 20510

The Honorable Bill Cassidy
U.S. Senate
455 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Whitehouse and Cassidy:

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 your request for information (RFI) based on the Pay PCPs Act (S. 4338).

We appreciate your leadership in identifying ways to improve physician reimbursement and value-based primary care, as doctors continue to face reimbursement challenges under the physician fee schedule (PFS). 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 physician reimbursement has dropped over 20% over the last 20 years when accounting for inflation. In addition, there is a widening gap between physician payment and increases in the 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 facing a national staffing emergency which could jeopardize access to high-quality, equitable care for patients and the communities they serve. The Association of Medical Colleges projects a physician shortage of over 86,000 by 2036. We have also seen how increased administrative burden contributes to physician burnout and clinicians leaving the field. The aging beneficiary population is also increasing service demand, while the supply of clinicians continues to decline, in no small part because an increasing proportion of physicians themselves are reaching retirement age. We appreciate the actions Congress has taken

to support physicians by passing one-time adjustments to partially offset decreases to the conversion factor. However, we continue to advocate for more sustainable solutions to ensure that updates to the PFS more accurately reflect the cost of delivering services.[1]

Considering these challenges, the AHA offers the following feedback on the Pay PCPs Act to ensure that the legislation can achieve the goal of providing more sustainable physician reimbursement and facilitating the transition to value-based primary care.

Hybrid Payments for Primary Care Providers

The Pay PCPs Act would establish a hybrid per-member-per-month (PMPM) and fee-for-service payment structure in the PFS for primary care. This type of structure can support migration to value-based models. However, we have concerns that the current proposal may result in payment cuts. Given the continued decreases in physician payment, further cuts cannot be absorbed.

While the proposal states that the PMPM should be "actuarily equivalent" to PFS amounts and "based on historical payments," we are concerned this still may result in payment decreases for certain providers. The proposal also states that the "Secretary may consider applying certain factors for different types of primary care providers." This implies that there may be variation in the PMPM depending on the type of provider without clarity of what and how it will be defined.

The bill also states "The Secretary ***may*** assess the need to risk adjust the prospective, PMPM payment and develop appropriate risk adjustment methodologies, taking into consideration ***only*** those factors that predict levels of primary care service utilization. Risk adjustment methodologies may incorporate clinical diagnoses, demographic factors, and other relevant factors such as social determinants of health." We are concerned that this provides latitude for the PMPM to not be risk-adjusted and would also restrict what could be included in the risk adjustment. Limiting the risk adjustment only to those factors that predict primary care utilization does not necessarily account for clinical complexity or social risk factors that may impact care management and the intensity of services required.

The proposed categories within the PMPM include care management services, communications (e.g., e-mails, phone calls and patient portal messages), behavioral health integration services, and office-based emergency and management (E/M) visits for new and established patients. These vary significantly in terms of effort and time required. For example, the office-based E/M codes for new and established patients

[1] https://www.aha.org/lettercomment/2024-06-17-aha-letter-senate-finance-committee-medicare-part-b-white-paper

vary significantly in time and required medical decision-making (hence the different reimbursement rates). Without appropriate risk adjustment, this provision could cut reimbursement for providers supporting patient panels with higher clinical complexity.

We are also concerned the bill includes a provision that "the Secretary may continue to pay ***through reduced fee-for-service payments*** for all other services not specified in paragraph (2)." This means that providers may receive decreased amounts for services like screenings, preventive services, annual wellness visits, vaccinations and preventive physical exams. These population health activities not only support prevention and early detection and treatment they also support reductions in long-term costs. These payment reductions could decrease access to these services.

The legislation also proposes to give CMS the ability to award bonus payments based on quality measures. Physicians participating in hybrid primary care payments also would be exempt from participation and payment adjustments under the existing physician Quality Payment Program. The AHA support the concept of bonus payments for delivering higher quality and safer care. We also appreciate that the legislation does not mandate specific measures or measurement topics, which would afford CMS and the field greater flexibility to select the measures that are most relevant and meaningful for assessing care, and to evolve any measures used in the program over time. However, to ensure that CMS uses multi-stakeholder engagement to identify appropriate measures for the model, we recommend that CMS be required to use the multi-stakeholder pre-rulemaking measure review process established under Section 1890A of the Social Security Act to review measures it is considering for bonus payments. Furthermore, to ensure that any bonus payments provided under the model are distributed fairly, CMS should be instructed to ensure measures include appropriate risk adjustment for clinical and social risk factors when relevant. Finally, while we support the concept of bonus payment for quality, we note that the exemption of participating physicians from the QPP may affect the overall distribution of performance in the Merit-Based Incentive Payment System (MIPS). We encourage you to consider giving CMS the flexibility under the MIPS to minimize precipitous payment swings to the physicians still in the program.

Lastly, this section of the bill does not provide a timeline for when this hybrid payment model would be enacted. Providers need flexibility (the ability to opt in and out of participation) and a gradual on-ramp in adopting value-based models.

Cost-Sharing Adjustments for Certain Primary Care Services

The Pay PCPs Act would reduce beneficiary cost-sharing for primary care services by 50% under the hybrid payment model. We support reducing beneficiary barriers to receiving care and appreciate your commitment to working toward that objective with this provision.

Technical Advisory Committee for Fee Schedule Rates

The Pay PCPs Act would establish a new technical advisory committee on relative value unit (RVU) updates and revisions. This technical advisory committee (TAC) would be comprised of 13 members including Medicare providers and providers from the Department of Veterans Affairs, Department of Defense, and primary care and family medicine providers. The committee would be chaired by the Centers for Medicare & Medicaid Services (CMS) who would review valuation methodologies, recommend changes in valuations, evaluate collapsing of codes and identify bundling opportunities.

We are concerned that the proposed membership of the TAC does not appear to include members who are part of the current Relative Value Scale Update Committee (RUC) process. There is a robust process already in place through the RUC for RVU valuation, updates, and revisions, which includes an expert panel of physicians to make recommendations on resource requirements for medical services. The TAC should be synchronized with these existing infrastructure elements and processes.

Additionally, we have concerns that the committee would be funded by transfers from the Medical Insurance Trust Fund ($5 million for fiscal years 2025-2029 for implementation and $10 million for research and development). This funding source means that the committee would be resourced out of cuts from other areas within the trust fund, not dedicated appropriations. We urge reconsideration of different ways for how the technical advisory committee is subsidized.

Incentivizing Participation in Alternative Payment Models and 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.

While the RFI focuses on a proposed hybrid primary care payment model, we would encourage solutions to foster growth in certain Alternative Payment Models (APMs).

Over the last 14 years, many of our hospital and health system members have participated in a variety of APMs, including primary care APMs and accountable care organizations (ACOs). 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 to make participation more attractive for potential participants. These principles are also relevant to approaching hybrid payment models. 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 before initiating the program.
- Adequate Risk Adjustment. Models should include adequate risk adjustment methodologies 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 and incorporate 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 who 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 transitioning 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. Model duration should be long enough 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 CMS dedicated resources (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. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 provided advanced APM 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.

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 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 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. **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 investing 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 to 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.

Conclusion

We appreciate your efforts to address the primary care 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