American Hospital Association™
Advancing Health in America

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March 27, 2025

Terry Mills Jr., M.D., M.M.M, Co-chair
Soujanya Pulluru, M.D., Co-chair
ATTN: Physician-Focused Payment Model Technical Advisory Committee
Assistant Secretary for Planning and Evaluation, Room 415F
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

RE: Request for Input Reducing Barriers to Participation in Population-Based Total Cost of Care Models and Supporting Primary and Specialty Care Transformation

Dear Co-chairs Mills and Pulluru,

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 share our comments regarding the Physician-Focused Payment Model Technical Advisory Committee's (PTAC) request for input on barriers to transitioning to population-based total cost-of-care (PB-TCOC) and primary and specialty care models.

In particular, we urge the PTAC to:

- **Adopt common principles that will support the implementation of PB-TCOC, primary and specialty care models.**
- **Recommend removal of high/low revenue thresholds, which inappropriately prevent certain providers from entering primary and specialty care models.**
- **Recommend extension of the advanced alternative payment model (APM) incentive payments.**
- **Recommend more sustainable reimbursement to support the transition to value better.**

Our detailed comments on these issues follow.

COMMON PRINCIPLES FOR PB-TCOC, PRIMARY CARE AND SPECIALTY MODELS

Our members support the U.S. health care system moving toward the provision of more outcomes-based, coordinated care, and we continue to redesign delivery systems to increase value and better serve patients. Over the last 15 years, our hospital and health system members participated in a variety of APMs, including primary care and specialty care models as well as total cost-of-care models.

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 transformation.

There are principles that we believe should guide the design of such APMs to make participation more attractive for potential participants, including hospitals, health systems and independent providers. 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 (e.g., integrating new staff, changing clinical workflows, implementing new analytics tools) and review data prior to initiating the program.
- **Adequate Risk Adjustment.** Models should include adequate risk adjustment methodologies to account for chronic risk factors and clinical complexity. This will ensure models do not inappropriately penalize participants for treating the sickest, most complicated and underserved patients.
- **Voluntary Participation and Flexible Design.** Model designs should be flexible, incorporating features such as voluntary participation and options for participants to leave models.
- **Balanced Risk Versus Reward.** Models should balance 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 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 the transition to value-based payment. To be successful in such models, hospitals, health systems and provider groups must, for example, invest in additional staffing and infrastructure to support care delivery redesign and outcomes tracking.

- **Transparency.** Models' methodologies, 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. Ideally, the Centers for Medicare & Medicaid Services (CMS) would dedicate staff and technology to helping provide program participants with more complete data as close to real-time as possible.
- **Waivers to Address Barriers to Clinical Integration and Care Coordination.** Models must include waivers to Medicare program regulations that inhibit care coordination and work against participants' efforts to ensure that care is provided in the right place at the right time.

We urge the PTAC to adopt these core principles for future APM model design.

REMOVING PROBLEMATIC LOW-REVENUE THRESHOLDS AS CRITERIA FOR APM PARTICIPATION AND INVESTMENT PAYMENTS

As mentioned above, hospitals and health systems are critical stakeholders in the journey to value. However, certain policies have hampered their ability to participate in certain models. For example, CMS has leveraged captured revenue to distinguish Accountable Care Organizations (ACOs) as "low-revenue" or "high-revenue," and by proxy, to identify ACOs as either physician-led (low-revenue) or hospital-led (high-revenue). The agency has then limited participation in certain APMs or qualification for advanced investment payments (AIPs) to only physician-led or low-revenue ACOs. It has based this policy on the faulty assumption that low-revenue ACOs perform better than high-revenue ACOs. **However, research shows there is no significant difference in performance between high- and low-revenue ACOs.**[1]

Furthermore, high-revenue ACOs often have more clinically complex, higher-cost patients attributed to their model. In addition, limiting eligibility for AIPs to only low-revenue ACOs inappropriately penalizes high-revenue ACOs, many of which are actually small organizations that critically need these resources for infrastructure investment to transition to APMs. For example, analysis suggests that critical access hospitals, federally qualified health centers and rural health centers are predominantly classified as high-revenue and therefore ineligible for AIPs. This partially explains the

[1] https://premierinc.com/newsroom/blog/pinc-ai-analysis-hospital-led-acos-perform-as-well-as-physician-led-models

disparity in APM adoption in rural and underserved areas, which the PTAC has previously highlighted. **We, therefore, urge PTAC to recommend the removal of these problematic high- and low-revenue thresholds that inappropriately preclude certain ACOs from obtaining necessary resources for infrastructure investment.**

EXTENSION OF ADVANCED APM INCENTIVE PAYMENTS

The bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provided incentive payments of 5% for providers participating in advanced APMs. 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 that promote population health. However, MACRA statute only provided the advanced APM bonuses through the calendar year (CY) 2024 payment period. Congress has passed single-year extensions (although at lower rates) through the CY 2026 payment period. These incentive payments provide crucial resources for providers considering the transition to PB-TCOC, primary and specialty care APMs. **As such, we urge PTAC to work with CMS to urge Congress to extend these incentive payments, which will better support providers transitioning to primary, specialty and total cost of care models.**

PHYSICIAN ACQUISITION AND PB-TCOC, PRIMARY AND SPECIALTY CARE MODELS

Some presenters in the March PTAC meeting cited the acquisition of physician practices as a barrier to APM competitiveness. However, this discussion did not fully address the situation. Specifically, much like hospitals and health systems, physicians across the country face increased costs, inadequate reimbursements and administrative burdens from public and private insurer practices. These factors create major barriers to operating an independent practice. Furthermore, the transition to value-based programs often requires infrastructure investment for electronic health records, quality reporting, analytics and support staff, which many practices may not have the economies of scale to support. As a result, physicians are increasingly looking for alternative practice settings that will provide financial security so they can focus more on clinical care and less on managing their own practice. While a disproportionate amount of attention has been placed on hospitals' acquisition of physician practices, the reality is that large commercial insurers have collectively invested billions in physician practice acquisitions. Based on an AHA analysis of Levin Associates data, private equity, physician groups and health insurers have acquired the vast majority of physician practices during the last five years.[2] Comparatively, hospitals rank relatively low in the acquisition of physician practices. In fact, private equity-backed startups have acquired 65% of physician practices from 2019 to 2023, and insurers have acquired 14% of practices in

[2] https://www.aha.org/system/files/media/file/2023/06/Private-Equity-and-Health-Insurers-Acquire-More-Physicians-than-Hospitals-Infographic.pdf

that same timeframe. This is compared to hospitals and health systems that have only acquired 6% of physician practices.

Therefore, we urge PTAC to recommend policies, such as more sustainable reimbursement aligned with inflation. Doing so will better support all providers' abilities to transition to value-based care.

We thank you for your consideration of our comments. Please contact me if you have questions, or feel free to have a member of your team contact Jennifer Holloman, AHA's senior associate director of payment policy, at jholloman@aha.org.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development