American Hospital Association™
Advancing Health in America

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January 16, 2026

The Honorable Greg Murphy
U.S. House of Representatives
407 Cannon House Office Building
Washington, DC 20515

The Honorable John Joyce
U.S. House of Representatives
2102 Rayburn House Office Building
Washington, DC 20515

The Honorable Kim Schrier
U.S. House of Representatives
1110 Longworth House Office Building
Washington, DC 20515

Dear Reps. Murphy, Joyce and Schrier, and Members of the Doctors' Caucuses:

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 comment on efforts to modernize the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and the challenges that remain for patients and doctors. We remain committed to working with Congress on identifying opportunities to enhance the efficacy and participation in programs authorized by MACRA, as well as transitioning our health care system from volume to value.

The adoption of the bipartisan MACRA was an important step in shifting the physician payment model from fee-for-service payments to quality and value metrics-based reimbursements by replacing the historical Sustainable Growth Rate (SGR) with the Quality Payment Program (QPP). The QPP consists of two tracks: the default Merit-based Incentive Payment System (MIPS) and a track for clinicians who exhibit sufficient levels of participation in certain advanced alternative payment models (APMs). As hospitals and health systems continue to deal with unprecedented strain due to rising inflation, massive staffing shortages and a variety of other factors, it is more crucial than ever to provide the field with financial stability and further the transition to value-based care.

Below are legislative reform recommendations for Congress to consider to further

support flexible implementation and widespread participation in value-based and alternative payment models while delivering improvements in the cost and quality of care.

Role of Alternative Payment Models in Value-based Care

Our members support the U.S. health care system progressing toward more outcomes-based, coordinated care and continue 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 15 years, many of our hospital and health system members have participated in a variety of APMs developed by the Center for Medicare & Medicaid Innovation (CMMI). Some APMs have generated net savings for taxpayers while maintaining the 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 would ensure models do not inappropriately penalize participants who treat 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 and/or waivers, and options for participants to leave the models.

Balanced Risk Versus Reward. Models should also balance the risk versus reward in a way that encourages providers to take on additional risk without penalizing those who need time and experience before they can 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. To be successful in their transition to value-based payment such models, hospitals, health systems and provider groups must invest in additional staffing and infrastructure to support care delivery redesign and outcomes tracking. Therefore, upfront investment incentives should be provided to support organizations.

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 remain in place long enough to truly support care delivery transformation and assess the impact on outcomes. Historically, models have been too short and/or have 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, 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 of statutory provisions and 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.

To ensure that these and other practical considerations are appropriately included in CMMI models, we believe the agency would benefit enormously from a periodic required consultation with 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.

Advanced APMs

Extension of Advanced APM Incentive Payments and Qualifying Thresholds. We appreciate Congress acting through a provision in the Consolidated Appropriations Act of 2024 to extend the Advanced APM incentive payments at 1.88% for the calendar year (CY) 2026 payment year and maintain the current thresholds for clinicians to achieve qualifying APM participant (QP) status. While lower than the 5% incentive payment rate established by MACRA, the incentive provides crucial resources to support non-fee-for-service programs, including meal delivery programs, transportation services, and digital tools and care coordinators, each of which promotes population health. Because participation in Advanced APMs has fallen short of initial projections, spending on the incentives has fallen well short of the amount the Congressional Budget Office projected when MACRA was originally scored. Repurposing the spending shortfall for APM incentive payments in future years, as well as maintaining the current thresholds for QP status, will accelerate our shared goal of increasing Advanced APM participation.

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 participated in Advanced APMs in 2019; 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.[1] 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 APMs. In particular, the AHA, since 2021, has supported the establishment of a Rural Design Center within 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 models, expand existing rural demonstrations and create separate rural tracks within new or existing CMMI models.

Merit-based Incentive Payment System

Improve Measures in 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

[1] U.S. Government Accountability Office (November 2021). "Information on the Transition to Alternative Payment Models by Providers in Rural, Health Professional Shortage, or Underserved Areas." https://www.gao.gov/assets/gao-22-104618.pdf

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 upstream risk factors beyond providers' control in calculating performance where necessary and appropriate.

Accountable Care Organizations

***Promote Gradual Transition to Performance-based Risk*.** We support the gradual transition to performance-based risk for certain Accountable Care Organizations (ACOs). For example, allowing ACOs inexperienced with performance-based risk to participate in one-sided shared savings models for a limited duration or indefinitely will provide more time for ACOs to invest in necessary infrastructure and adjust workflows. More gradual glidepaths to risk will help increase participation, experience and shared savings by empowering ACOs to maximize their contribution to patient care.

***Eliminate Low-revenue/High-revenue Qualifying Criteria*.** Congress also should require 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 supports underserved populations and/or if the organization is physician-led (low-revenue) or hospital-led (high-revenue). The agency has then limited participation in certain APMs or qualification for advance investment payments (AIPs) to only physician-led or low-revenue ACOs. 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.

High-revenue ACOs often have more clinically complex, higher-cost patients attributed to them. 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. In fact, analysis suggests that critical access hospitals, federally qualified health centers and rural health clinics are predominantly classified as high-revenue and therefore ineligible for AIPs. This partially explains the disparity in APM adoption in rural and underserved areas; assistance in investing in these efforts would help across the board.

Physician Fee Schedule Updates

Conversion Factor Updates. Physician reimbursement updates have not accounted for rising inflation or increasing input costs (like supply chain disruptions and workforce shortages). The widening gap between physician reimbursement rates and increases in the Medicare Economic Index poses significant threats to patient access and provider financial stability, particularly for safety-net providers. The latest Medicare Trustees

report acknowledged the inadequacy of Medicare physician payments and the potential impact on the quality of care. It states, "[c]ertain features of current law may result in some challenges for the Medicare program. For example, physician payment update amounts are specified for all future years. These amounts do not vary based on underlying economic conditions, and they are not expected to keep pace with the average rate of physician cost increases."[2]

The current conversion factor updates established in MACRA beginning in 2026 will only result in a 0.75% conversion factor update for clinicians who are QPs and 0.25% for all other clinicians. Indeed, these annual updates are insufficient, considering physician payment has dropped by 33% since 2001 when accounting for inflation.[3] While the conversion factor updates provided in H.R. 1 have provided some needed relief for CY 2026 in the interim, we would encourage more sustainable, real-time approaches to updating the conversion factor in line with inflation. Annual conversion factor updates should be made to reflect changes in input costs and inflation. This will support physicians' ability to transition to APMs.

Conclusion

The AHA appreciates the Doctors' Caucus recognizing the need for large scale reform to further the transition to value-based care. We look forward to working with you on ways to support greater participation and enhanced efficacy of MACRA on behalf of our patients and their communities.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President
Advocacy and Political Affairs

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[2] https://www.cms.gov/oact/tr/2025
[3] https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf