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Advancing Health in America

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Michael Chernew, Ph.D.
Chairman
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, D.C. 20001

Dear Chairman Chernew:

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 Medicare Payment Advisory Commission (MedPAC) November meeting sessions related to physician fee schedule payments, advanced alternative payment model (A-APM) incentives and Medicare Advantage (MA) network adequacy.

In particular, we:

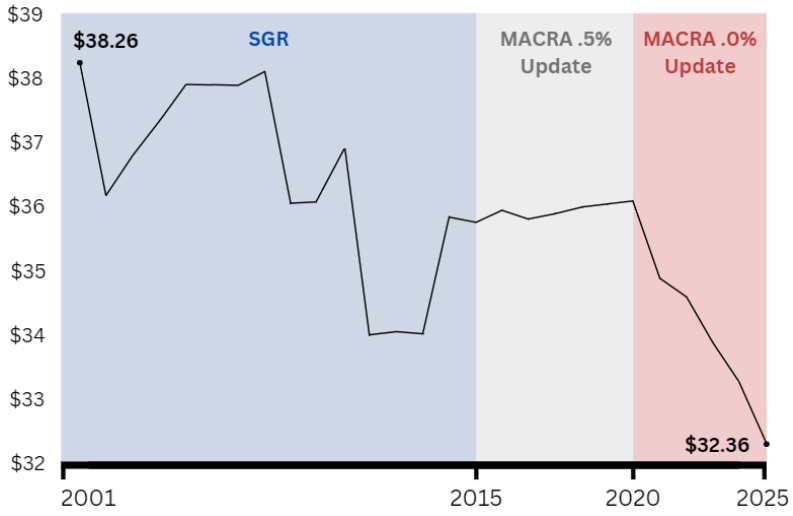
- **Directionally support updates to physician reimbursement that are tied to the Medicare Economic Index (MEI) but maintain that the discussed factor of MEI minus 1 is not nearly sufficient to make up for the existing shortcomings in physician reimbursement.**
- **Oppose penalizing facility-based providers by reducing their reimbursement rates. Doing so is not only inappropriate, but also would create an even greater incentive for physicians to seek out employment from other entities, such as private equity firms and health insurers (which have acquired the vast majority of physician practices during the last five years)**.
- **Support an extension of the A-APM incentive payments.**
- **Encourage the commission to examine the impact of the inadequate MA post-acute care network requirements on beneficiaries' access to care.**

Our detailed comments on these issues follow.

REFORMING PHYSICIAN FEE SCHEDULE UPDATES AND IMPROVING THE ACCURACY OF PAYMENTS

Updates to the physician fee schedule have remained woefully inadequate. Portions of the Medicare Access and CHIP Reauthorization Act (MACRA) were intended to fix issues with the sustainable growth rate (SGR) model by replacing gross domestic product increases to the conversion factor with updates that more accurately covered rising health care input costs (through MEI). However, the conversion factor has continued to decline in real dollars. Indeed, it decreased in real dollars by 15% from 2001 to 2025 based on the Physician Fee Schedule final rule (see Figure 1). The actual reduction when accounting for inflation from 2001 to 2024 was 29% according to the American Medical Association.

Figure 1. Trends in Medicare Physician Fee Schedule Conversion Factor 2001-2025



A recent Medicare Trustees report highlighted this inadequacy of Medicare physician payment and the potential for reimbursement decrements to adversely impact the quality of care for Medicare beneficiaries. Specifically, the report states that “certain features of current law may result in some challenges for the Medicare program … the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance” due to decreases in reimbursement.

We agree with the premise of the November MedPAC discussion that reform of physician fee schedule updates is necessary to address the inadequacy of physician payment. This is especially true since the current statutory updates that are scheduled to take effect in 2026 will only widen the gap between actual and adequate reimbursement and increase the risk for negative impacts on access to and quality of

care. However, we have feedback on the specific topic areas covered during the November meeting related to aligning reimbursement updates with a portion of MEI and improving the accuracy of payments:

Aligning Reimbursement Updates with a Portion of MEI

Presenters reviewed options to align reimbursement updates with a portion of MEI, specifically using a factor of MEI minus 1. **We directionally support updating physician payments by the MEI, but the discussed MEI minus 1 percentage point update is not nearly sufficient to make up for the existing shortcomings in physician reimbursement.** Indeed, it would only exacerbate the existing spiral downward in reimbursement through a compounding effect over time.

During discussion, the rationale for the MEI minus 1 update was that this is what the update to physician payment has amounted to over the last few years when accounting for the one-time Congressional increases. While we appreciate the one-time augments, there is nothing about these updates that suggest that they are adequate. Indeed, the conversion factor has continued to decline over time and has been insufficient to fully account for increased costs.

We encourage MedPAC to pursue annual updates to payment rates that are more in line with inflation and are made outside budget neutrality.

Accuracy of Fee Schedule Payment Rates

Presenters reviewed several examples of potential policies to address commissioners' concerns with the accuracy of fee schedule payment rates and to improve relative value unit (RVU) calculations. Policies reviewed included updating the allocation of RVUs by utilizing a rebased and revised MEI (as was included in the 2023 Physician Fee Schedule (PFS) proposed rule), improving the accuracy of global surgery bundles, and improving the accuracy of payments for indirect practice expenses (PE) by removing indirect PE from facility-based provider RVU calculations.

While we are encouraged that MedPAC is evaluating strategies to improve the accuracy of RVU calculations and reimbursement, we oppose policy options that penalize facility-based providers. **Doing so is not only inappropriate, but also would create an even greater incentive for physicians to seek out employment from other entities, such as private equity firms and physician group practices (which have acquired the vast majority of physician practices during the last five years)**.

Updating Allocation of RVUs. With respect to updating allocation of RVUs using the rebased and revised MEI, we request that MedPAC pause its evaluation of the issue until updated Physician Practice Information Survey (PPIS) data are available. As we have previously commented, the PPIS provides critical data to support updates to the

MEI and Resource Based Relative Value Scale. Indeed, integration of PPIS data was phased into CMS RVU calculations over the course of 2010-2014. Current rate setting is based on different data sources including the PPIS and supplemental data sources as required by Congress. PPIS data are expected to be available to CMS in early 2025 and it would be premature to discuss strategies to improve RVU calculations without these latest data.

We also caution that any updates to RVUs would cause a redistribution of payments based on physicians' geography and specialty. The same can be said for efforts to rebase and rescale MEI, as was suggested by the discussion. Historically, the MEI had been based on 2006 data representing only self-employed physicians. In the 2023 PFS final rule, CMS rebased and revised the MEI to use publicly available data sources for 2017 input costs that represent all types of physician practice ownership. However, it delayed implementation of the rebased and revised MEI because the revised weights will impact distribution of payments based on geography and specialty. **We have previously echoed CMS' concerns and therefore support a further delay in its implementation.[1] Redistribution of payments is always difficult, but it is fully inappropriate when the overall adequacy of payment is so poor, as is the case with the PFS.** It would cause already inadequate payment rates to then undergo significant cuts for specialties like cardiac surgery, neurosurgery and emergency medicine. In addition, geographic redistribution also would occur. For example, a significant reduction in the weight of office rent would lead to reductions in payments for urban localities. As such, we oppose any recommendations to implement the rebased and revised MEI at this time.

Improving the Accuracy of Payments for Indirect Practice Expenses. Presenters also reviewed policy examples to improve the accuracy of payments for indirect practice expenses and specifically presented an option to remove indirect practice expenses from RVU calculations for providers with a direct financial relationship with a hospital. However, the discussion failed to consider the adverse impact such a policy would have on these physicians. We oppose policies that would decrease reimbursement for facility-based providers. Doing so is inappropriate, especially when considering that the overall level of reimbursement under the PFS is so poor.

Presenters suggested that indirect practice expenses could be removed for these physicians because such costs may be duplicative. However, there are a variety of arrangements that may be included in the scope of "physicians with a direct financial relationship." We encourage MedPAC to present additional research on the types of arrangements that may be impacted and how various costs are allocated in these types of arrangements.

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[1] https://www.aha.org/system/files/media/file/2023/09/aha-comments-on-cms-physician-fee-schedule-proposed-rule-for-calendar-year-2024-letter-9-11-23.pdf

Additionally, much of the commissioner discussion on impacts focused on trends in physician acquisition and the premise that decreasing reimbursement for clinicians with a financial connection to hospitals would disincentivize physicians from seeking out hospital-based employment. This rationale is difficult to understand. There are a variety of factors contributing to physician practice acquisition,[2] and inadequate reimbursement is a leading one. Cutting payments to even lower levels for those seeking to find a way to obtain adequate reimbursement for their services puts these physicians in a difficult situation. It also hampers their ability to, for example, obtain some relief from other burdensome policies.

Notably, commercial insurer prior authorization policies have driven physicians to seek out hospital employment. Indeed, 84 percent of employed physicians reported that administrative burden had an impact on their employment decision, according to a recent survey of physicians conducted by Morning Consult on behalf of the AHA. This is not surprising considering physicians and their staffs report spending an average of nearly two business days per week completing prior authorizations alone.[3] Other physicians may seek out hospital employment to better support transition to value-based care, meet other regulatory requirements (like the Promoting Interoperability Program certified electronic health record technology standards) and focus more on direct patient care versus back office administrative work. **Despite efforts to paint hospitals and health systems as the sole cause of physician practice pattern changes, the truth is that policies such as already inadequate Medicare reimbursement and burdensome prior authorization requirements are driving physicians to seek out hospital employment.**

And while an inordinate amount of attention has been placed on *hospitals*' acquisition of physician practices, we'd be remiss if we did not point out that other entities, like 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.[4] Comparatively, hospitals rank relatively low in the acquisition of physician practices, as shown in Figure 2. **Creating an even lower reimbursement for facility-based providers will simply create a greater incentive for physicians to seek out employment from these other entities.**

Figure 2. Percentage of Physicians Acquired by Type of Entity (2019-2023)

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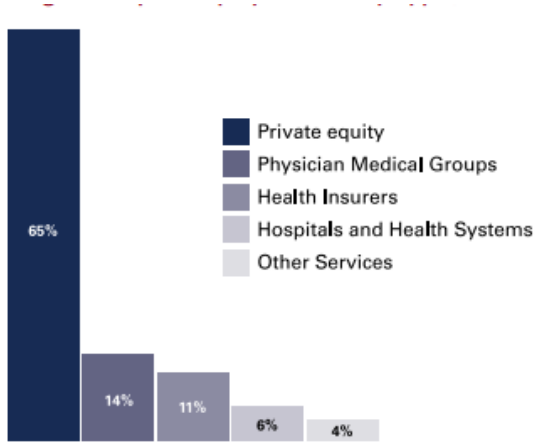
[2] https://www.aha.org/fact-sheets/2023-06-07-fact-sheet-examining-real-factors-driving-physician-practice-acquisition
[3] https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[4] https://www.aha.org/system/files/media/file/2023/06/Private-Equity-and-Health-Insurers-Acquire-More-Physicians-than-Hospitals-Infographic.pdf



Source: AHA analysis of LevinPro HG, Levin Associates, 2023, June, levinassociates.com. Only includes values for deals where the number of acquired physicians was reported. Certain acquirer types were also modified to more closely align with the services provided by the acquirer.

CONSIDERING THE A-APM BONUS

Presenters provided an overview of A-APM incentive payments, possible approaches to restructuring incentive payments and new policies that may influence the A-APM landscape. We appreciate that MedPAC is beginning to explore ways to incentivize A-APM adoption long-term. We also agree that in the near term, extension of A-APM incentives is necessary. **We support extending incentive payments to prevent attrition in A-APMs, and we support revisiting any potential restructuring of qualifying criteria at a later point.**

POST-ACUTE CARE MA PROVIDER NETWORKS

The AHA commends MedPAC's ongoing work to examine the access and care provided to MA beneficiaries. As the AHA has noted numerous times, enhancing network adequacy requirements and oversight would help improve beneficiary access to and quality of care. One such area where the AHA has raised concerns is the absence of many types of post-acute care providers from MA network adequacy requirements. As explained further below, this omission has a meaningful impact on the hundreds of thousands of beneficiaries who utilize these services on an annual basis.

As MedPAC is aware, traditional Medicare provides coverage for care provided at numerous types of post-acute care providers, including long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs) and home health agencies (HHAs). These settings continue care following acute-care hospitalizations and are critical to achieving patients' rehabilitation and recovery goals. However, despite these services being considered basic benefits under traditional Medicare, CMS only specifically includes SNFs in its network adequacy requirements for MA plans.

The lack of in-network post-acute care providers can be seriously disruptive for patients who need continued care at LTCHs, IRFs and HHAs. Indeed, AHA members report that they face increasing difficulty in finding placement for patients in need of this care. This results in patients being boarded in acute-care hospitals for longer than necessary, delaying their rehabilitation and recovery—which puts additional and unnecessary strain and cost on hospitals and impacts patients' overall health and recovery.

Due to the absence of these network adequacy requirements for post-acute care providers, the AHA commonly hears that MA plans will refuse to contract with certain post-acute providers in certain markets. For example, one member has found that shortcomings in these requirements resulted in a complete absence of in-network IRFs for most of the counties in a state with high MA penetration.

The omission of these provider types is especially striking given CMS' recent efforts to ensure parity in access to these services between MA beneficiaries and traditional Medicare beneficiaries. **Including these provider types in network adequacy requirements would be a commonsense step that would help ensure parity between the two programs.** As such, we have recommended to CMS that it explicitly include IRFs, LTCHs and HHAs in its MA network adequacy requirements in a manner that ensures that there are a sufficient number and type of each provider in MA networks**. We therefore encourage MedPAC to undertake an analysis of the impact of the current, inadequate MA post-acute network requirements on beneficiary access to care.** This should include examining not only the impact on direct access to post-acute services, but also how these omissions impact upstream providers such as acute-care hospitals, as well as overall outcomes for MA beneficiaries. The AHA stands ready to assist MedPAC with this work and welcomes any collaboration MedPAC may find helpful.

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 Shannon Wu, AHA's director of payment policy, at swu@aha.org or 202-626-2963.

Sincerely,

/s/

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

Cc: Paul Masi, M.P.P.
MedPAC Commissioners