



American Hospital
Association®

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

**Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Energy and Commerce
of the
U.S. House of Representatives**

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On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit comments on the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

The implementation of MACRA will have a significant impact not only on physicians, but also on the hospitals with whom they partner. According to the AHA Annual Survey, hospitals employed nearly 245,000 physicians in 2013, and had individual or group contractual arrangements with at least 296,000 more physicians. Hospitals that employ physicians directly may bear the cost of the implementation of and ongoing compliance with the new physician performance reporting requirements under the Merit-based Incentive Payment System (MIPS), as well as be at risk for any payment adjustments. Moreover, hospitals may be called upon to participate in alternative payment models (APMs) so that the physicians with whom they partner can qualify for the bonus payment and exemption from MIPS reporting requirements that accompanies the APM “track.”

For these reasons, the AHA is holding ongoing conversations with our membership, and has convened a clinical advisory group to identify the most important policy and operational implications of the MIPS and APMs for hospitals. We look forward to sharing additional insights with Congress and the Centers for Medicare & Medicaid Services (CMS) in the coming months. In the interim, we offer several overarching recommendations on



implementing the MIPS and APMs. In addition, we urge Congress to consider changes to the fraud and abuse laws to allow hospitals and physicians to work together to achieve the important goals of new payment models – improving quality, outcomes and efficiency in the delivery of patient care.

MIPS IMPLEMENTATION

The AHA urges the adoption of a MIPS that measures providers fairly, minimizes unnecessary data collection and reporting burden, focuses on important quality issues, and promotes collaboration across the silos of the health care delivery system. To achieve this desired state, we believe CMS should:

- Focus the MIPS measures required for reporting on national priority areas and consider limiting the number of measure reporting options over time;
- Employ risk adjustment rigorously – including sociodemographic adjustment, where appropriate – to ensure providers do not perform poorly in the MIPS simply because they care for more complex patients;
- Allow hospital-based physicians to use their hospital’s quality reporting and pay-for-performance program measure performance in the MIPS; and
- Align Electronic Health Record (EHR) Incentive Program changes for physicians with those of eligible hospitals, and refrain from adopting an “all-or-nothing” scoring approach.

Streamlining Measures and Data Reporting Options. **The AHA believes the implementation of the MIPS is a critically important opportunity to streamline and refocus physician quality measurement efforts so they align with concrete national priority areas for improvement across the entire health care system.** There are more than 250 individual measures in the current-law Physician Quality Reporting System (PQRS) and Value-based Payment Modifier programs that affect payment for calendar year (CY) 2017. While the volume of measures stems partially from the need to have measures relevant to the variety of specialties participating in these programs, we are concerned that measures have proliferated without a well-articulated link to specific national priorities or goals. Regardless of the specialty, the significant improvement in outcomes and health that patients expect and deserve is best achieved when *all* parties in the health care system are working toward the achievement of the same objectives.

For this reason, we have urged CMS to use the recommendations of the National Academy of Medicine’s (NAM) *Vital Signs* report to identify the highest priority measures for development and implementation in the MIPS. The *Vital Signs* report notes that progress in improving the quality of health care has been stymied by discordant, uncoordinated measurement requirements from CMS and others. To ensure that all parts of the health care system – hospitals, physicians, the federal government, private payers and others – are working in concert to address priority issues, the *Vital Signs* report recommends 15 “Core Measure” areas, with 39 associated

priority measures. These areas represent the current best opportunities to drive better health and better care, based on a comprehensive review of available literature. Each stakeholder would be measured on the areas most relevant to their role in achieving common goals and objectives. While we caution against using the core measure areas to assess providers on aspects of care that may be beyond the scope of their operations, the NAM report provides an important uniting framework that will help make all stakeholders more accountable and engaged in measurement and improvement.

The AHA also urges the adoption of a limited number of measure data reporting options over time. The existing PQRS includes seven different measure data reporting options, including two different kinds of registries, EHRs, claims-based reporting and a web interface. We believe the proliferation of PQRS reporting options stems from a well-intentioned desire to provide a multitude of ways for physicians to report data, thereby avoiding payment penalties. Nevertheless, the wide variation in reporting options may impinge upon CMS’s ability to compare performance accurately in the MIPS. There are clear indications that, even when reporting on the same quality measures, measure results may vary across the different reporting mechanisms. For example, CMS began to calculate separate performance benchmarks for physicians and groups reporting measures using EHRs due to concerns that EHR-derived measure results differ from other data collection modes. To minimize disruption, the agency likely should retain most or all of the existing PQRS measure reporting options in this initial years of the MIPS. However, CMS should undertake further study to determine which submission modes most appropriately balance data accuracy and provider burden.

Risk Adjustment. The AHA strongly urges the robust use of risk adjustment – including sociodemographic adjustment, where appropriate – to ensure providers do not perform poorly on MIPS simply because they care for more complex patients. It is a known fact that patient outcomes are influenced by factors other than the quality of the care provided. In the context of quality measurement, risk adjustment is a widely accepted approach to account for some of the factors outside the control of providers when one is seeking to isolate and compare the quality of care provided by various entities. As noted in the National Quality Forum’s 2014 report on risk adjustment and sociodemographic status, risk adjustment creates a “level playing field” that allows fairer comparisons of providers. Without risk adjustment, provider performance on most outcome measures reflect differences in the characteristics of patients being served, rather than true differences in the underlying quality of services provided.

CMS must be especially attentive to the impact of sociodemographic factors on performance measures used in the MIPS and APMs, and incorporate sociodemographic adjustment when necessary and appropriate. The evidence continues to mount that sociodemographic factors beyond providers’ control – such as the availability of primary care, physical therapy, easy access to medications and appropriate food, and other supportive services – influence performance on outcome measures. For example, in January 2016, NAM released the first in a planned series of reports that identifies “social risk factors” affecting the health outcomes of Medicare beneficiaries and methods to account for these factors in Medicare payment programs. Through a comprehensive review of available literature, the NAM’s expert panel found evidence that a wide variety of social risk factors may influence performance on certain health care outcome measures such as readmissions, costs and patient experience of care.

These community issues are reflected in readily available proxy data on socioeconomic status, such as U.S. Census-derived data on income and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. The agency also recently proposed to adjust several measures in the Medicare Advantage Star Rating program for sociodemographic factors. Yet, to date, CMS has resisted calls to incorporate sociodemographic adjustment into the quality measurement programs for hospitals.

Unfortunately, failing to adjust measures for sociodemographic factors when necessary and appropriate can harm patients and worsen health care disparities by diverting resources away from physicians, hospitals and other providers treating large proportions of disadvantaged patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that contribute to poor outcomes. Physicians, hospitals and other providers clearly have an important role in improving patient outcomes and are working hard to identify and implement effective improvement strategies. However, there are other factors that contribute to poor outcomes. If quality measures are implemented without identifying sociodemographic factors and helping all interested stakeholders understand their role in poor outcomes, then the nation's ability to improve care and eliminate disparities will be diminished.

Develop a MIPS Participation Option for Hospital-based Physicians. The MACRA includes a provision allowing CMS to develop MIPS participation options for hospital-based physicians to use their hospital's CMS quality and resource use measure performance in the MIPS. **The AHA strongly supports the implementation of such an option in the MIPS, and believes it would help physicians and hospitals align quality improvement goals and processes across the care continuum.** We recognize that the agency will need to establish a process for hospitals and physicians to designate themselves for this participation option, as well as parameters to ensure there is an adequately strong relationship between the hospitals and physicians. For example, CMS could require active membership on the medical staff or an employment contract. The agency could potentially validate the relationship using claims data elements, such as inpatient and hospital outpatient department place of service codes.

EHR Incentive Program Requirements and Performance in the MIPS. The incorporation of the Medicare EHR Incentive Program for Eligible Professionals (EPs) into the MIPS presents an opportunity for CMS to improve the program in a number of ways. **First, the AHA urges the use of a methodology that does not score the MIPS' EHR Incentive Program category using an "all-or-nothing" approach. That is, CMS should not require EPs to meet all of the meaningful use objectives and measures in order to receive points in the category.** Instead, we recommend that attainment of 70 percent of the objectives and measures in meaningful use afford an EP with full credit under this category. Additionally, to the extent that CMS modifies the definitions, structure and reporting requirements of the EHR Incentive Program in the development of metrics for the MIPS and APMs, **the AHA recommends the agency apply such modifications in a consistent manner for all EHR Incentive Program participants – EPs, eligible hospitals and critical access hospitals.** This alignment is critical to ensuring the ability to share information and improve care coordination among providers across the continuum. Lastly, CMS should use its flexibility under the statute to reorient the EHR Incentive Program so that the use of certified technology supports the achievement of national quality improvement priorities.

ALTERNATIVE PAYMENT MODEL IMPLEMENTATION

The MACRA provides incentives for physicians who demonstrate significant participation in APMs. **The AHA supports accelerating the development and use of alternative payment and delivery models to reward better, more efficient, coordinated and seamless care for patients.** Many hospitals, health systems and payers are adopting such initiatives with the goal of better aligning provider incentives to achieve the Triple Aim of improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of health care. These initiatives include forming accountable care organizations (ACOs), bundling services and payments for episodes of care, developing new incentives to engage physicians in improving quality and efficiency, and testing payment alternatives for vulnerable populations.

Despite the progress made to date, the field as a whole is still learning how to effectively transform care delivery. There have been a limited number of APMs introduced so far, and existing models have not provided participation opportunities evenly across physician specialties. Therefore, many physicians may be exploring APMs for the first time. **As a general principle, the AHA believes the APM provisions of the MACRA should be implemented in a broad manner that provides the greatest opportunity for physicians who so choose to become qualifying APM participants.** Particularly in the early years of MACRA implementation, the agency should take an expansive approach that encourages and rewards physicians who demonstrate movement toward APMs.

In particular, CMS should adopt an expansive definition of “financial risk” when identifying APMs that “count” for purposes of the MACRA bonus payment. Specifically, CMS’s definition of “financial risk” should go beyond simply requiring an entity to take on downside risk; it also should recognize the significant up-front investment that must be made by providers who develop and implement APMs. Providers who participate in APMs invest significant time, energy and resources to develop the clinical and operational infrastructures necessary to better manage patient care. For example, an AHA analysis estimated start-up costs of \$11.6 million for a small ACO and \$26.1 million for a medium ACO. If CMS does not acknowledge this type of significant up-front investment as the organizational risk that it is, and instead defines “financial risk” very narrowly to require downside risk, the 99 percent of ACOs that participate in Track 1 of the Medicare Shared Savings Program would not qualify.

The AHA believes that such a result is undesirable and at odds with the MACRA’s clear goal of rewarding those physicians who have been early adopters of APMs. In addition, this could inhibit physician movement toward APMs, particularly in early years, if physicians cannot engage with existing model participants – which have a head start on building infrastructure and engaging in care redesign – and instead must start from scratch. While we acknowledge CMS’s interest in encouraging providers to move toward accepting increased risk, such an interest must be balanced with the reality that providers are starting at different points, and will have different learning curves. CMS should define “financial risk” in a way that provides a path for physicians who are interested in participating in risk-bearing models – particularly those who are exploring such models for the first time – rather than serving as a barrier to entry.

Finally, given the increasing prevalence of Medicare Advantage (MA), the AHA urges CMS to explore ways to capture risk-sharing arrangements for care provided to beneficiaries enrolled in MA plans in the APM framework.

LEGAL IMPEDIMENTS TO IMPLEMENTATION OF NEW PAYMENT MODELS

By tying a portion of most physicians' Medicare payments to performance on specified metrics and encouraging physician participation in APMs, the MACRA marks another step in hospitals', physicians' and other health care providers' movement to a value-based paradigm from a volume-based approach. To achieve the efficiencies and care improvement goals of the new payment models, providers must break out of the silos of the past and work as teams. Of increasing importance is the ability to align performance objectives and financial incentives among providers across the care continuum.

To do that, a legal safe zone for those efforts is needed that cuts across the fraud and abuse laws – specifically, the physician self-referral (Stark) law, anti-kickback statute and certain civil monetary penalties (CMPs). In our view, these laws are not suited to the new models. The statutes and their complex regulatory framework are designed to keep hospitals and physicians apart – the antithesis of the new models.

To us the answer seems clear: Congress should adopt a single, broad exception that cuts across the Stark law, the anti-kickback statute and relevant CMPs for financial relationships designed to foster collaboration in the delivery of health care and incentivize and reward efficiencies and improvements in care. We recommend that the exception be created under the anti-kickback statute and arrangements protected under the exception be deemed compliant with the Stark law and relevant CMPs.