

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

May 11, 2016

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 are reviewing the details of the recent notice of proposed rulemaking (NPRM) implementing the MACRA, and look forward to sharing additional insights with Congress and the Centers for Medicare & Medicaid Services (CMS) in the coming weeks and 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;
- Allow hospital-based physicians to use their hospital’s quality reporting and pay-for-performance program measure performance in the MIPS;
- 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; and
- Align Electronic Health Records (EHR) Incentive Program changes for physicians with those of eligible hospitals.

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.** Providers are overwhelmed by conflicting, unfocused quality measure requirements that hinder their ability to improve patient care. 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. This has resulted in data collection requirements that often add burden without adding value to quality improvement or transparency efforts.

The recent NPRM includes some encouraging proposals that may help to streamline physician quality measurement requirements. We appreciate CMS’s proposal to reduce the number of measures required for reporting from the PQRS’s nine measures to six measures. We also applaud CMS’s recent work with private insurers and physician groups to reach agreement on common sets of physician quality measures that can be used in both CMS and private payer pay-for-performance programs. CMS proposed many of the measures from these common measure sets for the MIPS. Physicians and hospitals alike spend significant resources reporting on multiple versions of measures assessing the same aspect of care to meet the differing

requirements of CMS and individual private payers. Greater alignment of measures across public and private payers could potentially reduce unnecessary data collection burden and free up additional resources for improving care.

However, we believe significant work remains to ensure measurement efforts across the health care system are focused on the most important quality issues. As described in the next section, we believe CMS has additional opportunities to streamline measurement and promote focus through implementing a MIPS reporting option for hospital-based physicians. We also stand ready to work with CMS to better align Medicare hospital quality measures with those used in the private sector. Lastly, we believe CMS must ensure that the quality measurement requirements for *all* providers share a common set of goals and objectives. Indeed, 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) 2015 *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.

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.** While we are disappointed that CMS did not propose a hospital-based physician reporting option in the NPRM, we commend the agency for soliciting further input on the design of this option. We look forward to working with CMS and other stakeholders in the coming months to make hospital-based physician reporting in the MIPS a reality.

We recognize that CMS 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 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.

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.

EHR Incentive Program Requirements and Performance in the MIPS. CMS proposes to designate the EHR Incentive Program as the Advancing Care Information (ACI) performance category within the MIPS and proposes changes to the program requirements. **The AHA supports changes to the meaningful use program for physicians that begin to offer flexibility in how physicians and other eligible clinicians are expected to use certified EHRs**

to support clinical care. As these changes are implemented, it will be essential to ensure that program requirements are aligned across all participants, including physicians, hospitals, and critical access hospitals (CAHs). This alignment is essential to ensuring the ability of providers to share information and improve care coordination across the continuum.

We are encouraged by the beginning of a transition away from the meaningful use “all or nothing” scoring approach. The AHA has long advocated for the elimination of the “all-or-nothing approach” to meaningful use of EHRs. It is unfair that providers could make good faith efforts to comply, may actually comply with a large percentage of the requirements, expend significant resources and funds in doing so, but still fall short. **The AHA supports the elimination of an all or nothing approach that makes clear that attainment of 70 percent of the objectives and measures in meaningful use afford full credit in this performance category.**

CMS proposes two pathways for provider participation in the ACI performance category with base requirements and an additional performance score. The base score would focus on the ability of MIPS-eligible clinicians to use the certified EHR while the performance score would continue to count the number of times the certified EHR is used. **The AHA appreciates the movement toward flexibility in the measures used in the health information exchange and public health reporting. However, we remain concerned that the reporting burden will remain high. In addition, we note that flexibility has not been proposed for other requirements in the ACI performance category that we believe are important to success – the number of measures that a MIPS-eligible clinician would be required to meet, the length of the reporting period in the first reporting year of a new edition of certified EHR, and the readiness of the standards and technology to support successful attainment of the measures.** Prior experience has demonstrated that these issues have consistently presented challenges to successfully meeting program requirements.

CMS also proposes to eliminate the separate requirements for clinical quality measure reporting within the ACI performance category and instead require the submission of quality data for measures specified for the quality performance category, and would encourage submitting quality measure data using certified EHR technology. **The AHA supports this alignment of clinical quality measure reporting.**

The AHA strongly supports the goals of information sharing to improve care, engage patients, and support new models of care. The proposed rule would require all hospitals, CAHs and physicians that participate in the meaningful use program to attest that they did not “knowingly and willfully take action to limit or restrict the compatibility or interoperability” of their certified EHR. Additionally, the proposed rule would require two additional attestations:

- 1) How the technology is implemented to conform with standards, allow patient access and support secure and trusted bi-directional exchange; and
- 2) That hospitals, CAHs or physicians responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers, and other persons, regardless of the requestor’s affiliation or technology vendor.

The AHA is concerned that the current technology and infrastructure do not support the level of exchange contemplated by these proposed attestation requirements.

APM 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.

For this reason, we are disappointed that CMS has proposed a narrow definition of “financial risk” when identifying advanced APMs, which “count” for purposes of the MACRA bonus payment. Specifically, CMS proposes to define “financial risk for monetary losses” to require an entity to take on downside risk. This approach fails to 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. Despite this significant financial investment, the vast majority of Medicare Shared Savings Program ACOs that participate in Track 1 will not qualify as an advanced APM under CMS’s proposal.

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.

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 the health care field’s movement to a value-based paradigm from a volume-based approach. To achieve the efficiencies and care improvement goals of the new payment models, hospitals, physicians and other health care 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.

CONCLUSION

Thank you for the opportunity to share our views on the implementation of the MACRA. The AHA looks forward to working with Congress, CMS and all other stakeholders to ensure MACRA enhances the ability of hospitals and physicians to deliver quality care to patients and communities.