

**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**

March 21, 2018

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and 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 submit comments on the implementation of alternative payment models (APMs) in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Now entering its second year, the MACRA’s Quality Payment Program (QPP) continues to have a significant impact, not only on physicians and others clinicians, but also on the hospitals and health systems with whom they partner to deliver care. There remains strong interest from the field in participating in advanced APMs to support new models of care, and to qualify for the bonus payment and exemption from the QPP’s Merit-based Incentive Payment System (MIPS). However, opportunities to access the advanced APM track remain significantly constrained. In the calendar year (CY) 2018 QPP final rule, the Centers for Medicare & Medicaid Services (CMS) estimates that as few as 10 percent of eligible clinicians will qualify for the advanced APM track in 2018.

The AHA urges Congress to continue working with CMS to provide greater opportunity to participate in advanced 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 the new payment models – improving quality, outcomes and efficiency in



the delivery of patient care. Finally, opportunities remain to improve fairness and reduce burden under the MIPS.

BROADENING OPPORTUNITIES FOR ADVANCED APM PARTICIPATION

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 Medicare APMs introduced so far, and existing models have not provided participation opportunities evenly across physician specialties. Therefore, many physicians likely are 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, CMS should take an expansive approach that encourages and rewards physicians who demonstrate movement toward APMs. The agency also should ensure that it designs APMs with a fair balance of risk and reward, standardized and targeted quality measures and risk adjustment methodologies, physician engagement strategies, and readily available data and feedback loops between CMS and participants.

The AHA continues to be concerned that CMS's regulations only allow participation in APMs with downside financial risk to "count" toward the advanced APM track. This approach excludes current Medicare APMs with the largest number of participants, including Track 1 of the Medicare Shared Savings Program (MSSP). We urge Congress to work with CMS to expand its definition of financial risk in the QPP's advanced APM track to include the investment risk borne by providers who participate in APMs.

CMS's narrow definition 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.

We appreciate that CMS has offered the Track 1+ MSSP model in an attempt to create a glide path to assuming downside risk. Nevertheless, clinicians participating in shared savings-only models are working hard to transform care delivery; under CMS's policy, their significant investments and efforts will not be sufficiently recognized. Regardless of

whether an APM entails downside risk, providers must acquire and deploy infrastructure and enhance their knowledge base in areas, such as data analytics, care management and care redesign. Further, one metric for APM success – meeting financial targets – may require providers to reduce utilization of certain services, such as emergency department visits and hospitalizations through earlier interventions and supportive services to meet patient needs. However, this reduced utilization may result in lower revenues. Providers participating in APMs accept the risk that they will invest resources to build infrastructure and potentially see reduced revenues from decreased utilization, in exchange for the potential reward of providing care that better meets the needs of their patients and communities and generates shared savings. This risk is the same even in those models that do not require the provider to repay Medicare if actual spending exceeds projected spending.

In addition, restricting the advanced APM track to models with downside risk may inhibit the movement toward APMs, especially among early APM adopters. If clinicians cannot engage with existing model participants – which have a head start on building infrastructure and engaging in care redesign – they 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, 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.

Outdated fraud and abuse laws, however, are standing in the way of achieving the goals of the new payment systems, specifically, the physician self-referral (Stark) law and anti-kickback statute. These statutes and their complex regulatory framework are designed to keep hospitals and physicians apart – the antithesis of the new value-based delivery system models. A 2016 AHA [report](#), *Legal (Fraud and Abuse) Barriers to Care Transformation and How to Address Them (Wayne’s World)*, examines the types of collaborative arrangements between hospital and physicians that are being impeded by these laws and recommends specific legislative changes.

Congress should create a clear and comprehensive safe harbor under the anti-kickback law for arrangements designed to foster collaboration in the delivery of health care and incentivize and reward efficiencies and improvement in care. Arrangements protected under the safe harbor would be protected from financial penalties under the anti-kickback civil monetary penalty law. In addition, the Stark Law should be reformed to focus

exclusively on ownership arrangements. Compensation arrangements should be subject to oversight solely under the anti-kickback law.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

As the MIPS is the QPP track in which the vast majority of clinicians will participate, the AHA believes it is vitally important that CMS implement the MIPS in a way that measures providers accurately and fairly; minimizes unnecessary data collection and reporting burden; focuses on high-priority quality issues; and fosters collaboration across the silos of the health care delivery system. To achieve this desired state, we have recommended that CMS prioritize the following policy approaches:

- Adopt gradual, flexible increases in MIPS reporting requirements in the initial years of the program to allow the field sufficient time to plan and adapt;
- Streamline and focus the MIPS quality and cost measures to reflect the measures that matter the most to improving outcomes;
- Allow facility-based clinicians the option to use their facility's CMS quality reporting and pay-for-performance results in the MIPS;
- Employ risk adjustment rigorously – including sociodemographic adjustment, where appropriate – to ensure providers do not perform poorly in the MIPS simply because of differences in clinical severity and communities they serve; and
- Align the requirements for eligible clinicians in the advancing care information (ACI) performance category with the requirements for eligible hospitals and critical access hospitals (CAHs) in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

CMS has made progress in addressing several of the above priorities. For example, in the first two MIPS performance years (CYs 2017 and 2018), CMS has used an incremental approach to increasing MIPS data reporting requirements, and reduced the number of required quality measures from the previous Physician Quality Reporting System. **In addition, the AHA applauds CMS for responding to our long-standing request to develop a facility-based measurement option for the MIPS that will be available in 2019. While we believe it could be adopted sooner, the option ultimately will help clinicians and hospitals alike spend less time collecting data, and more time improving care.** Congress can help make the reporting option even more effective by encouraging CMS to consider future expansion of the option to a broader array of facility types, such as post-acute care providers.

Furthermore, Congress should encourage CMS to continue refining its approach to accounting for both clinical and sociodemographic factors in measuring performance outcomes. CMS took an important step toward recognizing the impact of sociodemographic and other risk factors on outcomes by adopting a “complex patient bonus” in the MIPS in 2018. Clinicians receive up to five bonus points on their MIPS Final Scores based on a Medicare

claims-derived proxy for patient complexity (Hierarchical Condition Categories, or HCCs), as well as the number of patients dually eligible for Medicare and Medicaid that a clinician or group treats. Dual-eligible status is a proxy for sociodemographic factors.

However, experience from the use of HCC scores in the value-based payment modifier (VM) raises significant questions about its adequacy in accounting for patient risk. CMS used HCC scores to provide modest increases to performance scores to groups treating significant numbers of high-risk patients. Unfortunately, the results of the 2016 VM program show that group practices caring for patients with more clinical risk factors were still significantly more likely to receive negative VM adjustments. Furthermore, while dual-eligibility is an established proxy for sociodemographic status, there are others – such as income and education – that may be more accurate adjusters for particular measures. We urge that the patient complexity bonus be viewed as an interim step while more sophisticated adjustment approaches are developed.

Lastly, the AHA believes that any future changes to MIPS policy should be informed by data, experience and input from this field. That is why we believe the Medicare Payment Advisory Commission (MedPAC) recommendation in its March 2018 *Report to Congress* to replace the MIPS with a new voluntary value program (VVP) is premature.

The proposed VVP would withhold at least 2 percent of clinician payment unless clinicians either joined an advanced APM or agreed to be measured as part of a group on measures of “population-based outcome measures” (e.g., mortality, readmissions, hospital admissions), patient experience and cost.

The AHA is concerned that the VVP has been proposed without the benefit of data and experience to show where the MIPS is working well and where it needs improvement. Clinicians and the hospitals with whom they partner are at the very beginning of putting the MACRA’s policy requirements into action. In fact, the first performance period for the MIPS and APMs ended on Dec. 31, 2017; clinicians will submit data by Mar. 31, 2018. In addition, clinicians and hospitals already have invested significant resources to comply with the MIPS. Changing course on the MIPS so soon after program implementation could lead to confusion in the field and require clinicians to spend time and resources deciphering the requirements of a new program rather than on improving care.

The AHA also questions the feasibility of several aspects of the VVP. At the core of the VVP’s design is the requirement to join a group practice. The AHA has always supported the notion of clinicians coming together voluntarily to participate in clinician quality efforts as a group practice, as it provides a way to share resources and improvement strategies. However, the group approach that MedPAC proposes would introduce several practical problems. Specialist physicians may find it difficult to form or join appropriate groups because the broad population-based measures envisioned in the VVP may not apply to their work. Furthermore, there is considerable national variation in market composition and the ability of clinicians to collaborate on improving performance. We fear that some groups could be “groups in name only,” rather than true collaborations to enhance the quality of care. This would seem to run counter to the intent of the VVP.

Finally, the AHA is concerned by the heavy reliance on claims-based measures in the VVP. Without question, using Medicare claims data rather than requiring clinicians to submit chart-abstracted data entails less data collection effort on the part of clinicians. However, claims data cannot and do not fully reflect the details of a patient’s history, course of care and clinical risk factors. Such information is crucial to performing the risk adjustment that most outcome measures require to fairly compare provider performance. As a result, many claims-derived outcome measures do not accurately reflect provider performance. Basing clinician performance on unreliable data would be highly problematic.

CONCLUSION

Thank you for the opportunity to share our views on the implementation of advanced APMs in MACRA’s QPP. 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, and advance health in America.