American Hospital Association™
Advancing Health in America

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July 30, 2018

Representative Mike Kelly
United States House of Representatives
1707 Longworth House Office Building
Washington, DC 20515

Representative Markwayne Mullin
United States House of Representatives
1113 Longworth House Office Building
Washington, DC 20515

Representative Ron Kind
United States House of Representatives
1502 Longworth House Office Building
Washington, DC 20515

Representative Ami Bera
United States House of Representatives
1431 Longworth House Office Building
Washington, DC 20515

RE: Request for Feedback Regarding Innovative Policy Ideas that Improve Quality of Care and Lower Costs for Consumers

Dear Representatives Kelly, Kind, Mullin and Bera:

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 respond to your request for feedback regarding innovative policy ideas that improve quality of care and lower costs for consumers.

As described in your request for feedback, the Health Care Innovation Caucus (the Caucus) will examine innovative policy ideas that encourage the development and scaling of value-based payment arrangements to improve care and lower costs for patients. To do so, the Caucus will gather information about lessons learned from the implementation of existing payment models, barriers to the expansion of these models and the technologies needed to support them.

Our members support the health care system moving toward the provision of more accountable, coordinated care, and they are redesigning delivery systems to increase value and better serve patients. **As such, the AHA supports the advancement of innovative payment models and the technologies needed to support them**. In particular, the AHA appreciates that you have formed this bipartisan caucus to remove barriers to value-based payment reform and support the elements essential for success in value-based payment arrangements. Our members look forward to collaborating with you as you continue to consult stakeholders and drive improvement in patient care.

ELEMENTS ESSENTIAL TO THE SUCCESS OF INNOVATIVE PAYMENT MODELS

As the health care field has grown increasingly more complex and consumer-focused, Medicare, Medicaid and commercial payers have adapted by accelerating the transformation from a volume-driven system to one that rewards providers for the delivery of value and positive patient outcomes. Innovative value-based payment arrangements have been a key driver of that transition. Now, providers and payers are looking to scale the initial versions of value-based arrangements and develop new models to improve quality of care and lower expenditures for patients, providers and the health care system.

Key principles. **Based on our members' experience with designing, implementing and scaling value-based payment arrangements, we believe that certain principles should apply across all value-based projects and models:**

- Transparency – Models should be designed transparently and shared so that participants can make fully-informed decisions about participation.
- Fully integrated care – Models should promote fully integrated care that considers the 'whole person,' including his or her behavioral and mental health, as well as social determinants of health.
- Balance risk vs. reward – Models should balance the risk versus reward equation in a way that encourages providers to take on additional risk but does not penalize those that need additional time and experience before they are able to do so, and that supports the significant upfront investment providers must make to participate in these models.
- Guard against fragmentation – Models should be evaluated in a holistic fashion so that they create aligned incentives across the delivery system, including consistent approaches to measuring cost and quality performance. Congress, the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (CMMI) should avoid the uncoordinated proliferation of a large number of models, which could lead to a "pile on" effect that makes it far more challenging for hospitals, health systems and post-acute care providers to focus and execute to the best of their ability.
- Barriers to clinical integration – Models should waive the applicable fraud and abuse laws that inhibit care coordination to enable participating hospitals to form the financial relationships necessary to succeed.
- Barriers to care coordination – Models should provide maximum flexibility to identify and place beneficiaries in the clinical setting that best serves their short- and long-term recovery goals. This entails waiving certain Medicare program regulations that frequently inhibit care coordination and work against participants' efforts to ensure that care is provided in the right place at the right time.
- Timely availability of data – Model participants should have readily available, timely access to data about their patient populations.

- Risk adjustment – Models should include adequate risk adjustment methodologies to ensure they do not inappropriately penalize participants treating the sickest, most complicated and most vulnerable patients.
- Regulatory burden – Models should seek to minimize regulatory burden to the greatest extent possible, such as those related to quality reporting requirements, as discussed in Regulatory Overload – our recent report on the regulatory burden faced by hospitals, health systems and post-acute care providers.
- Partnerships – Models should leverage partnerships where appropriate, such as through coordination across federal agencies.

Measuring what matters. In addition to applying the above principles to all value-based payment arrangements, **we urge the Caucus to ensure that measures developed for and included in these arrangements are closely targeted to the quality and safety issues that have the greatest impact on patient outcomes.** Quality measures are invaluable tools to help providers assess progress and identify opportunities to improve care. But if too many measures are included in value-based payment arrangements, or the measures fail to assess important aspects of care, then the measures can divert time and resources away from what matters the most – improving care.

Data collection and reporting activities would be more valuable if federal agencies, private payers and others requiring quality data agreed on a manageable list of high-priority aspects of care. Then, providers could use a small and critically important set of measures to track and report on progress toward improving the care delivered and the outcomes for patients. An example of this type of thinking can be found in CMS's "Meaningful Measures" framework, which the agency is using to streamline and prioritize measures in its quality programs. **As existing models change and mature and new models emerge, we urge the Caucus to seek opportunities to standardize quality metrics and reporting platforms across programs and models to maximize the time participants can spend on patient care instead of conflicting reporting requirements.**

Attention to affordability. As health care costs rise, individuals, employers, government and payers are seeking greater value for their health care dollars. Risk-based models offer an important opportunity for our members to improve the affordability of care without compromising access or quality. **Therefore, we urge the Caucus to pay special attention to the issue of affordability so as to improve the value of health care in communities nationwide**.

To provide leadership to our members on the issue of affordability – many of whom are already implementing innovative payment models to lower costs for patients – the AHA created The Value Initiative, a platform for hospitals and health systems to engage in dialogue and foster change on this important issue with key stakeholders. We urge the Caucus to examine this work and learn from these hospitals' experience as it develops innovative policy ideas related to value-based payment arrangements. We also

recommend that the Caucus integrate strategies to make care more affordable into any policy options that promote innovative payment arrangements.

BARRIERS THAT LIMIT THE FULL POTENTIAL OF VALUE-BASED PAYMENT ARRANGEMENTS

As our members endeavor to implement value-based payment arrangements that reward physicians for delivering integrated, high-quality, cost-effective care with better outcomes, fraud and abuse requirements remain one of the main impediments to care transformation. Specifically, these requirements greatly inhibit the ability of hospitals and health systems to design clinical integration arrangements, innovative partnerships and flexible payment terms that could help providers deliver complete and coordinated care. The outdated legal framework of the fraud and abuse laws also impede our members' ability to maintain the health of patients outside their four walls and fill gaps in needed support when patients return to their communities. Current safe harbors and exceptions do not cover many of the innovations that our members seek to implement, and fraud and abuse waivers for certain programs or projects are too limited to enable hospitals and health systems to make broad-scale changes.

In order to address the barriers to innovation that the fraud and abuse laws pose, we recommend that Congress create new safe harbors under the Anti-Kickback Statute and reform the physician self-referral law, more commonly known as the Stark law, and certain civil monetary penalties to foster and protect arrangements that promote value-based care. In our February 2017 report on barriers to care transformation, we outlined the challenges facing hospitals and physicians in their attempts to share risk and reward to achieve the goals of innovative payment arrangements, and we proposed several solutions to addressing these challenges. **Specifically, we urge Congress to consider creating two new safe harbors to the Anti-Kickback Statute to achieve care transformation – one for incentive payment and shared savings programs, and another for assistance to patients.**

Regarding the Stark law, we commend CMS for examining changes necessary to modernize Stark through its recent request for information (RFI) regarding the physician self-referral law. We plan to submit comments in response to the RFI that will highlight the barriers to care coordination that the Stark law poses and recommend solutions to remove those barriers. **We urge the Caucus to support the work of CMS. Doing so would accelerate the transformation to a system of value-based care by removing regulatory obstacles to care coordination.**

We also urge the Caucus to address the following issues that create legal and regulatory hurdles, limiting the full potential of innovation.

- **Limitations on the use of telehealth**. Virtual connections can create convenience and ensure access to specialists in areas with shortages. While

providing waivers for some advanced payment models, Medicare still limits the locations, services and technology that it will pay for telehealth. And, variations in state licensure requirements create an expensive administrative burden when providing care across state lines.

- **Billing requirements**. The billing process can be difficult for consumers. However, improving the billing process requires collaboration with payers and the government to streamline steps such as benefits determination and prior authorization, and create a more consumer-friendly experience.

- **Accreditation standards**. The conditions of participation need to be streamlined and modernized to focus on compliance with requirements that are essential to achieving better outcomes for patients.

- **Privacy rules**. Analytics and Artificial Intelligence are expected to fuel innovation and care coordination in the coming years. However, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules that apply to health care providers, insurers and clearing houses strictly limit how information gathered during the care process can be shared and used. Increasingly, technology companies not covered by HIPAA are collecting health information directly from patients, as well as from health care providers (with patient consent). The data-driven future of health care will need a set of privacy rules that offers reasonable protections while ensuring providers have access to the data that will support medical decision-making and care coordination.

THE ROLE OF TECHNOLOGY AND HEALTH IT IN VALUE-BASED CARE

An efficient and effective infrastructure for health information exchange is central to providers' ability to deliver high-quality coordinated care, support new models of care and engage patients in their health. Hospitals and health systems already are investing in information exchange to better support care coordination and transitions across settings of care by deploying systems to share health records with other providers of care. However, to create widespread interoperability, the necessary technical and organizational infrastructure must be available and allow for efficient exchange. In addition, all parties to exchange must be using compatible technology in consistent ways. All of this must be achieved in a way that simultaneously allows the free flow of information to others who have a legitimate reason to have it while protecting the information from hackers and others with nefarious intent. **In order to advance the interoperability infrastructure needed for innovative payment models to flourish, we urge the Caucus to support CMS and the Office of the National Coordinator for Health Information Technology as they work to implement the 21st Century Cures Act.**

We also recommend that you partner with CMS and other federal entities to support the widespread availability of patient identifiers. Providers continue to

experience challenges in identifying patients and matching them to their medical records. Safe and effective interoperability of health information that originates in disparate sources depends on the accurate link of a patient with the correct record. The nation lacks a single mechanism for identifying individuals such as a unique patient identifier. Patient safety concerns arise when data are incorrectly matched, such as a patient's current medication not being listed in the medical record or the wrong medications are included in the record. A single solution that would match individuals across IT systems would allow providers to know with confidence that a patient being treated in an emergency department is the same patient that a physician in another location diagnosed with an acute or chronic health condition that requires ongoing management. This also would greatly improve providers' ability to deliver cross-continuum, coordinated care, which is a significant component in the move toward a system of value-based care.

Again, we thank you for your focus on improving value for patients and providers and for your consideration of our comments. If you have any questions, please feel free to contact me or have a member of your team contact Aimee Kuhlman, senior associate director of federal relations at (202) 626-2291 or akuhlman@aha.org.

Sincerely,

/s/

Maryjane A. Wurth
Executive Vice President/COO
President/CEO, Health Forum