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Advancing Health in America

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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 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 provide input on the implementation of the Merit-based Incentive Payment System (MIPS), which is part of the Quality Payment Program (QPP) mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Now midway through its second performance year, the QPP continues to have a significant impact on physicians and others clinicians, and on the hospitals and health systems with whom they partner to deliver care. As the MIPS is the "default" QPP track in which the vast majority of clinicians participate, the design and implementation of its policies have especially far-reaching ramifications for the field.

The Centers for Medicare & Medicaid Services (CMS) has made important progress in implementing a MIPS program that balances flexibility for providers with raising the bar on participation and performance. At the same time, we urge Congress to continue working with the agency to improve the fairness of the MIPS and mitigate its administrative burden.

ADDRESSING MIPS POLICY PRIORITIES

The AHA has urged that the MIPS be implemented 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 served; and

- Align the requirements for eligible clinicians in the Promoting Interoperability (formerly known as Advancing Care Information) performance category with the requirements for eligible hospitals and critical access hospitals.

The AHA is pleased that CMS has made important progress in addressing the above priorities. For example, in the first two MIPS performance years (calendar years 2017 and 2018), CMS adopted gradual increases to the length of reporting periods, data standards, and the performance threshold for receiving positive or negative payment adjustments. The AHA also commends CMS for using its new "Meaningful Measures" initiative to propose the removal of more than 30 measures from the MIPS program in the 2019 physician fee schedule proposed rule. CMS also proposed steps to bring alignment of promoting interoperability across hospitals and clinicians.

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. We believe the option ultimately will help clinicians and hospitals alike spend less time collecting data and more time improving care. Under this approach, clinicians that spend 75 percent or more of their time in a hospital inpatient or emergency department setting can use their hospital's CMS hospital value-based purchasing program performance in the MIPS without having to report separate quality or cost data. In short, it means those clinicians and hospitals can focus their efforts on the same set of priorities, and see their performance rewarded in a consistent fashion.

Congress can help make facility-based measurement even more beneficial and effective by encouraging CMS to consider future expansion of the option to a broader array of facility types, such as post-acute care and inpatient psychiatric care providers. In the most recent proposed rule, CMS has signaled an openness to expanding the option.

Congress also 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 methodologies for accounting for social and clinical risk continue to evolve.

EVOLVING MIPS IN THE FUTURE

As with any significant policy change, the QPP and MIPS will need ongoing refinements to ensure goals are met. Indeed, that is why Congress used the Bipartisan Budget Act of 2018 to make several welcome technical amendments to the MIPS, such as allowing CMS more time to increase the weight of the MIPS cost category and applying payment adjustments to only covered professional services. These changes give providers and CMS greater flexibility, and improve the program's fairness.

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

The proposed VVP would withhold at least 2 percent of clinician payment unless clinicians either joined an advanced alternative payment model (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 submitted data on Mar. 31, 2018, and are in the process of reviewing their final performance for 2017. 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 supports the idea 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 and unfair.

MOVING FROM MIPS TO ADVANCED APMS

Many hospitals and health systems remain eager to partner with clinicians to participate in advanced APMs to support new models of care and earn an exemption from the MIPS. Yet, opportunities to access the QPP's advanced APM track remain constrained. We urge Congress to continue working with CMS to provide greater opportunity to participate in advanced APMs. Our March 2018 statement before the House Ways and Means Subcommittee on Health provides additional policy recommendations in this area.

CONCLUSION

Thank you for the opportunity to share our views on the implementation of the MIPS 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.