

**Statement of  
the American Hospital Association  
for the  
Committee on Finance  
of the  
U.S. Senate**

**Medicare Physician Payment Reform After Two Years:  
Examining MACRA Implementation and the Road Ahead**

May 8, 2019

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 the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Three years into its implementation, the QPP continues to have a significant impact, not only on physicians and other 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 alternative payment models (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) 2019 Physician Fee Schedule final rule, the Centers for Medicare & Medicaid Services (CMS) estimated that as few as 16 percent of eligible clinicians will qualify for the advanced APM track in 2021.

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.

Our detailed comments follow.

## **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 and underpaid services.

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 thus far, and existing models have not provided participation opportunities evenly across physician specialties. Therefore, many physicians are still exploring APMs for the first time or at only the early stages of transforming care under APM arrangements. **As a general principle, the AHA believes the APM provisions of MACRA should be implemented in a broad manner that provides the greatest opportunity for physicians who so choose to become qualifying APM participants.** 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.

**While we acknowledge and appreciate CMS's development and implementation of more APMs that qualify as advanced APMs, we continue to be concerned that these existing and announced APMs offer too few opportunities for certain types of providers that serve more dispersed and vulnerable populations.** For example, rural providers often lack the access or ability to make investments needed to participate in new models, among the many other challenges they face given their geographic location, low patient volumes, aging infrastructure in which they practice, workforce shortages and other factors. High-risk APMs are not accessible to these providers, even those that wish to participate in them. Similarly, post-acute and behavioral health providers serve particularly challenging and unique populations and thus are in need of APM options tailored to the degree of risk they can manage given their patient populations. **CMS should consider these and other providers when designing APMs and expand opportunities for them to participate in advanced APMs that offer them targeted resources and a manageable amount of risk.**

## 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.**

## ADDRESSING MIPS POLICY PRIORITIES

The AHA has urged 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 because of differences in clinical severity and communities they serve.
- 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 (CAHs).

**The AHA is pleased that CMS has made important progress in addressing the above priorities.** For example, in the first three MIPS performance years (calendar years (CY) 2017 through 2019), CMS has 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 remove 26 measures from the MIPS program in the CY 2019 physician fee schedule final rule. CMS also has brought the Promoting Interoperability programs for clinicians and hospitals into far greater alignment. We offer our perspective on other MIPS policy priorities below.

**Facility-based Measurement. The AHA applauds CMS for responding to our long-standing request to develop a facility-based measurement option for the MIPS that is available starting this year. 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, emergency department (ED) setting or on-campus hospital outpatient 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 last year’s rulemaking process, CMS signaled an openness to expanding the option.

**MIPS Cost Category. We urge Congress to work with CMS to take a more gradual approach to increasing the weight of the MIPS cost category, as well as adding measures to the cost category.** Hospitals and clinicians alike are focused on improving the value of care and need well-designed measures of cost and resource use to help inform their efforts. However, we believe CMS’s recent decision to increase the weight of the cost category to 15 percent of the total MIPS score and to adopt eight new episode-based cost measures should be delayed until CY 2022 at the very earliest.

**Serious questions remain about the accuracy and reliability of all of the measures in the MIPS cost category, making it problematic to increase the weight beyond the 10 percent weight adopted for CY 2020 payments.** CMS’s recent changes to the Medicare spending per beneficiary (MSPB) measure underscore this point. In the CY

2017 QPP final rule, CMS chose to remove specialty adjustment from the MSPB measure, and lower the MSPB minimum volume threshold from 125 cases to just 20 cases. Yet neither of these changes had strong data or analysis to support them. Specialty adjustment in MSPB is intended to account for differences in specialty mix that can affect the costs of care. Furthermore, the MSPB measure once had a minimum case threshold of 125 cases because CMS's analyses suggested that many cases were necessary to get a statistically reliable result. We do not believe the measure materially changed in such a way that it achieves reliable results without the higher case threshold. Taken together, we worry that these measure changes will result in rewards or penalties based on differences in patient population or statistical noise, and not real performance differences.

**The AHA also remains concerned that the basic performance attribution approach for the MSPB and cost per capita measures in the MIPS lacks a “line of sight” from clinician actions to measure performance.** The measures do not reflect the performance of just the clinician or group practice. Rather, the measures attribute *all* of the Medicare Parts A and B costs for a beneficiary during a defined episode (three days prior to 30 days after an inpatient admission for MSPB, and a full year for total cost per capita). Yet, these costs reflect the actions of a multitude of health care entities – hospitals, physicians, post-acute providers, etc. The ability for any clinician or group to influence overall measure performance will vary significantly depending on local market factors, including the prevalence of clinically integrated networks.

**Lastly, while we appreciate the concept behind the episode-based measures, we are concerned that clinicians have had limited time to understand their baseline performance and implement changes to improve performance.** In contrast to the two total cost measures, the episode-based measures include only the items and services related to the episode of care for a particular treatment or condition. This measurement approach can result in a more clinically coherent set of information about cost. However, this approach also necessitates the use of algorithms for identifying costs relevant to an episode, and a multi-step approach for attributing measure performance. This methodology adds necessary rigor, but also complexity. Yet, clinicians only had information from a “dry run” of the episode measures that CMS conducted using data from 2016 before CMS added the measures to the program.

Enhancing Risk Adjustment. **Congress should encourage CMS to continue refining its approach to accounting for both clinical and social risk 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 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 it meets its goals. 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.

**Indeed, 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 (MedPAC) recommendation in its March 2018 *Report to Congress* to replace the MIPS with a new voluntary value program (VVP) is premature.** We refer the Committee to our [March 2018 statement](#) to the committee for additional information.

## **CONCLUSION**

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