American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

November 12, 2013

The Honorable Dave Camp
Chairman
U.S. House Committee on Ways and Means
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Max Baucus
Chairman
U.S. Senate Finance Committee
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Camp, Chairman Baucus and Members of the Committees:

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) is pleased to respond to your request for comments on your discussion draft for solutions to the current problems with the Medicare payment system for physician services. Thank you for seeking our input.

Physicians need stable and adequate payment for services provided to Medicare beneficiaries. The most recent payment fix passed by Congress prevented a 26.5 percent cut to Medicare physician payments scheduled to take effect in 2013, and provided physicians with a zero percent update for the remainder of the year. Unfortunately, this fix, along with other provisions, was funded in part by an $11 billion reduction to hospital inpatient Medicare payments. This fix is soon due to expire and on Jan. 1, Medicare physician payments are scheduled to be reduced by 24.4 percent.

While averting a cut in payments to physicians is essential, it should not be financed by reducing payments to hospitals. The AHA will continue to work with Congress to find a permanent solution to the Medicare physician payment problem; however, we remain strongly opposed to additional cuts that could be harmful to hospitals' ability to fulfill their mission of caring.

The AHA supports the general direction of the Committees' proposal, but has concerns about specific proposals, such as the details of Alternate Payment Models (APMs), streamlining quality measures, impact on medical specialties, and potential offsets. In addition, permanent Medicare physician payment reform should remove barriers to clinical integration of health providers, and include medical liability reform. Our detailed comments follow.

ALTERNATE PAYMENT MODELS

The AHA supports efforts to develop APMs and to support providers in the movement to value-based payments. As the committees' proposal pushes providers towards greater risk-based contracting, it is important to note that a more comprehensive definition (beyond requiring two-sided risk) of what qualifies as an APM is necessary. We request to be a part of discussions with you as this important component is developed.

The current proposal would also be difficult to apply to specialists. Given the limited Medicare and commercial APMs available for specialists and the fact that many of the measures would not be applicable to them as they fall under the clinical practice improvement activities and those quality components, this proposal may disproportionately negatively impact specialists. We recommend the committees consider the relevance and applicability of this and subsequent iterations of the proposal to specialists.

QUALITY MEASURES AND PAY-FOR-PERFORMANCE

The AHA believes that rigorous, publicly transparent quality measurement is an important part of improving health care. Hospitals and their affiliated physicians have long supported the need for public reporting of quality measures in order to share important and reliable quality information with the communities they serve, and also to identify opportunities to improve care and track improvements. *The Patient Protection and Affordable Care Act* (ACA) expanded national measurement efforts for hospitals, increasing the financial stakes of quality performance for health providers. Accordingly, the AHA supports the Committees' proposal to expand quality reporting measurement in the physician community.

That said, the implementation of future quality reporting and pay-for-performance efforts related to physician services must recognize the resource constraints of the field. Given the resources needed to collect and report data on quality measures, measures must be carefully selected to ensure they address the highest priority areas. Moreover, pay-for-performance programs must be carefully implemented to ensure that they fairly assess performance, and do not impose unwarranted reductions to reimbursement.

As Congress considers the creation of additional quality measurement and pay-for-performance programs, we offer the following principles to guide their design. These principles are consistent with those outlined in our June 2013 statement on federal quality measurement and pay-for-performance efforts in general, and our August 2013 letter on post-acute care reform:

- **Quality measurement programs should be aligned with broader national quality improvement priorities for all health care providers.** Unfortunately, federal quality reporting and payment programs have proliferated without strong alignment to national priorities or a fundamental understanding of the most important changes to be made to produce better patient outcomes. Indeed, the sheer volume of measures and disparate ranking and rating efforts has become overwhelming and

distracting to quality improvement efforts, with different priorities, different goals and different incentives impeding efforts to enhance coordination across the care continuum.

- **Measures in quality reporting and pay-for-performance programs must be endorsed by the National Quality Forum (NQF) to ensure they are sufficiently rigorous for use in accountability programs. The Measure Applications Partnership (MAP) also should review the measures before being incorporated into programs to ensure they are aligned with national priorities.** Rigorous measures aligned with national quality priorities would ensure focused attention on the most critical areas of improvement and promote an efficient use of limited quality improvement resources. It also would encourage coordination of efforts among all health care providers.

- **To ensure uniformity of purpose across the health care system, behavioral health quality reporting and payment programs should align with the National Quality Strategy (NQS).** The ACA directs the Department of Health and Human Services (HHS) to create an NQS that identifies critically important areas for improvement, sets goals and selects measures to be used in federal programs to encourage achievement of those goals. This plan is meant to set priorities for the health care system as a whole, and relies on input from affected stakeholders, including hospitals, patients, purchasers, insurers and public policy experts. The AHA strongly supports the premise of the NQS – that is, our nation's health care system can be improved by focusing on aspects of care that a broad array of stakeholders believes to be important.

- **Pay-for-performance programs should assess multiple aspects of care, and use incentive structures that recognize providers for both achievement versus national benchmarks and improvement versus baseline performance.** The inclusion of multiple aspects of care within one pay-for-performance program provides a consistent evaluation mechanism and incentive structure, reducing confusion about how performance is evaluated. We also believe this incentive structure provides greater inducement for providers to improve performance.

- **The AHA believes that measures should be added to pay-for- performance programs in a gradual, step-wise process. This will ensure that programs assess performance accurately, and address issues of high priority.** Our guidelines are as follows:

  - Measures implemented in federal programs should be reviewed and endorsed by the NQF prior to inclusion in a federal program to ensure that each measure is scientifically sound, useable and feasible to collect.

  - Federal programs should require that the MAP review all measures being considered for inclusion in the program before they are formally proposed in rulemaking. As noted above, the MAP's review should be informed by overall

health care system priorities, thereby allowing an assessment of whether measures support improvement in the most important areas.

- Before being used in a pay-for-performance program, each measure should be included in a national public reporting program for at least one year. In this manner, the results can be monitored to be sure there is variation in performance; the causes for variation can be identified and, if related to patient characteristics (such as severity of illness), appropriate adjustments can be made to the measure; and potential unintended consequences of measurement and public reporting can be identified and addressed.

- Monitoring of a measure's performance should continue throughout its use in a pay- for-performance program. When there is evidence of consistent and sustained excellent performance, the measure should be retired from performance-based incentive programs and public reporting programs. This will create room for identification of additional improvement opportunities and inclusion of new measures.

Clinical Integration

The AHA strongly believes that any bill to permanently address the SGR system should remove barriers to clinical integration of health providers. The ACA provides limited opportunities for providers to better integrate care to serve Medicare and Medicaid beneficiaries. To enable the clinical integration that is essential to improve the efficiency and effectiveness of the health care delivery system, regulatory oversight of the financial relationships between hospitals and physicians must change.

Current clinical integration efforts span the spectrum from initiatives aimed at achieving greater coordination around a single clinical condition or procedure to fully integrated hospital systems with closed medical staffs consisting entirely of employed physicians. Over the years, many hospitals have made tremendous strides in improving coordination across the care continuum, while others have been challenged; some hospitals have focused their efforts on privately insured patients in order to avoid the legal entanglements associated with government reimbursement. Hospitals seeking greater clinical integration first need to overcome the legal hurdles presented by antitrust, patient referral (Stark), civil monetary penalty (CMP) law, anti-kickback laws, the Internal Revenue Code and many others.

The development of accountable care organizations (ACOs) as part of the Medicare Shared Savings Program marked an historic regulatory effort among several federal agencies to achieve the goal of better coordinated care. In a major win for patients, the antitrust agencies abandoned their proposed requirement for mandatory antitrust review before hospitals could even apply for the ACO program, and instead offered limited guidance for all ACOs. Significantly, the waivers from the fraud and abuse laws for ACOs go well beyond the very limited protections proposed by the Centers for Medicare & Medicaid Services and the HHS Office of Inspector General.

While three of the four federal agencies made significant strides with respect to ACOs, it is disappointing that none went further to include any clinically integrated arrangements among providers. The AHA will continue to urge agencies to go farther and to remove barriers beyond ACOs so all patients have the benefit of clinically integrated care from organizations providing accountable care.

To that end, the AHA advocates the following changes:

Antitrust. Antitrust guidance is narrowly and technically drafted without any binding effect; as a result, caregivers can neither readily understand the guidance nor completely rely on it. The AHA has advocated that the antitrust agencies – the Department of Justice's Antitrust Division and the Federal Trade Commission – issue more comprehensive, user-friendly guidance that clearly explains what issues must be resolved to ensure that clinical integration programs comply with antitrust law.

Patient Referral (Stark) Law. The Stark law has grown beyond its original intent, to prevent physicians from referring their patients to a medical facility in which they have an ownership interest, to limit practically any financial relation- ship between hospitals and physicians. The law's strict requirements mandate that compensation be set in advance and paid on the basis of hours worked. Consequently, payments tied to quality and care improvement could violate the law. One effective solution: remove compensation arrangements from the definition of "financial relationships" under the law and instead rely on other laws already in place for needed oversight.

Civil Monetary Penalty Law. The CMP law is a vestige of concerns raised in the 1980s that Medicare patients might not receive the same level of services as other patients after the inpatient hospital prospective payment system bundled multiple services under a single Diagnosis-Related Group (DRG). In today's environment, the CMP is impeding clinical integration programs. While health reform is encouraging the use of best practices and clinical protocols, using incentives to reward physicians for following best practices and protocols can be penalized under current enforcement of the CMP law. This law must be updated to apply only to the reduction or withholding of *medically necessary* services.

Anti-kickback. Anti-kickback laws originally sought to protect patients and federal health programs from fraud and abuse by making it a felony to knowingly and willfully pay anything of value to influence the referral of federal health program business. Today's expanded interpretation includes any financial relation- ship between hospitals and doctors – this negatively affects clinical integration. The AHA supports broader "safe harbor" language and core requirements that provide reasonable flexibility to hospitals and caregivers.

Internal Revenue Service (IRS) Rules. The IRS rules prevent a tax-exempt institution's assets from being used to benefit any private individual, including physicians. This pertains to clinical integration arrangements between not-for- profit hospitals and private doctors. As other regulatory barriers are addressed, the IRS will need to issue an Advisory Information Letter or a Revenue Ruling recognizing that clinical integration programs that reward private doctors for improving quality and efficiency do not violate IRS regulations.

MEDICAL LIABILITY REFORM

The AHA also strongly believes that any bill to permanently address the SGR system must include meaningful medical liability reform. Such reform would not only improve access to physician and hospital care, but would also provide a funding source to help pay for a permanent fix to the physician payment system.

The high costs associated with the current medical liability system not only harm hospitals and physicians, but also patients and their communities. Across the nation, access to health care is being negatively impacted as physicians move from states with high insurance costs or stop providing services that may expose them to a greater risk of litigation. The increased costs that result from the current flawed medical liability system not only hinder access to affordable health care, they also threaten the stability of the hospital field, which employed 5.3 million people in 2009, and continues to be one of the largest sources of private-sector jobs.

An estimated $50 to $100 billion is spent annually on defensive medicine – services not provided for the primary purpose of benefiting the patient, but rather to mitigate the risk of liability. To help make health care more affordable and efficient, the current medical liability system must be reformed. The AHA believes that Congress should include meaningful medical liability reform in its legislation to permanently address the physician payment system, and that any savings from such reform be directed to this purpose.

Thank you for giving the AHA an opportunity to provide you with input on Medicare physician payment. If you have additional questions or would like to discuss policy options at length, please feel free to contact me or Erik Rasmussen, AHA senior associate director, at (202) 626-2981 or erasmussen@aha.org.

Sincerely,

Rick Pollack
Executive Vice President