Patrick Conway's Hearing
"MACRA"
Before
E&C Health Subcommittee

March 17, 2016

Attachment — Additional Questions for the Record

The Honorable Joseph R. Pitts

1. **Can you detail the steps CMS has already taken to engage the stakeholder community notably physicians and providers, as well as their specialty associations, in the development of the MACRA rule? Specifically, MACRA explicitly requires CMS to engage directly with physician stakeholders to implement various aspects of MACRA, can you update us on this communication to date and what will be forthcoming?**

Answer: CMS is committed to engaging with stakeholders in implementing this important legislation. In CMS's calendar year 2016 Medicare physician fee schedule proposed rule, we solicited comments regarding implementation of certain aspects of the Merit-based Incentive Payment System (MIPS) and broadly sought comments on the topics in MACRA, including the framework for providing the incentive payments associated with APM participation. On October 1, 2015, we released a Request for Information (RFI), asking for comments from the stakeholder community on many topics related to MIPS, alternative payment models (APMs), quality measurement, and meaningful use of certified electronic health records (EHRs). Further, in December 2015, CMS, in conjunction with the Office of the National Coordinator for Health Information Technology, issued an RFI to assess policy options that could improve the effectiveness of the certification of health information technology and specifically the certification and testing of EHR products used for the reporting of quality measures. We know physicians and other clinicians have a lot of demands on their time, and we are grateful for the robust response from the stakeholder community to these requests for feedback. We are currently in the process of reviewing and incorporating the feedback we received, and we anticipate releasing a proposed MACRA implementation rule, including a 60-day comment period, this Spring. We look forward to continued engagement from Congress and the health care community.

In addition, through MACRA, Congress established a new independent advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC meets on a periodic basis to review physician-focused payment models submitted by individuals and stakeholder entities and prepare comments and recommendations on proposals that are received, explaining whether models meet criteria for physician-focused payment models. The 11 members of the PTAC, who were appointed by the Comptroller General, are experts in physician-focused payment models and related delivery of care, including researchers, practicing physicians, and other stakeholders. The first PTAC meeting was held on February 1, 2016, and presentations from the meeting are available online. CMS looks forward to receiving recommendations for new physician-focused payment models. We will need stakeholder

engagement with the PTAC, including physicians and other clinicians, to suggest well designed, robust models that could meet the statutory criteria to be an eligible APM.

2. **The final rule for MACRA implementation for performance year 2017 is expected to be released later this year. Some have worried that a few months is not enough time for practices to transition to MIPS. How does CMS plan to accommodate practices during this transition period?**

    - **The legislation provides CMS with instruction and funding for physician outreach in this transition and information on how to report - what type of education and support will be provided to practices?**

    - **Will specific efforts be undertaken for small or rural practices?**

    - **Can you outline these efforts and what we can tell our providers to expect as far as resources and engagement from CMS?**

Answer: CMS knows that physicians and other clinicians may need assistance in transition to the Merit-based Incentive Payment System (MIPS) and we want to make sure that they have the tools they need to succeed in a redesigned system. In addition, Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as regional extension centers and regional health collaboratives to offer guidance and assistance to physicians and other clinicians. The technical assistance is to focus on the performance categories under MIPS, helping to make it as seamless as possible for these clinicians and practices to comply with MIPS requirements and helping interested practices transition to implementation of and participation in an alternative payment model. We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance.

In addition to the MACRA funding, in September 2015, CMS awarded $685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and spend dollars more wisely. The Transforming Clinical Practice Initiative is one of the largest federal investments designed to support physicians and other clinicians in all 50 states through collaborative and peer-based learning networks.

3. **When does CMS plan to notify physicians whether they are qualified APM participants for the 2019 payment year?**

4. **Will CMS administer the 2019 APM payment update in a way that allows physicians who are qualified APM participants to forego participation in MIPS in 2017 or do you think all physicians will need to assume they must meet the 2017 MIPS reporting requirements because they will not know whether they meet the 2019 APM payment update requirements?**

5. **Would you be willing to speculate as to how many physicians will qualify for the APM bonus payment in the initial years of its availability? If the number is low, why?**

Answer 3-5: MACRA established a particular definition of alternative payment models (APMs) and established what qualifies as an "eligible APM," for purposes of exempting eligible professionals from the Merit-based Incentive Payment System (MIPS) and allowing eligible professionals to receive a special incentive payment as a qualifying APM participant. While creating this new category of eligible APMs provides for promising incentives for a growing number of eligible professionals in the future, we expect the initial years to be ones of development as we apply lessons learned and continue to refine the program. The statute creates a high bar for eligible APMs, and many currently existing APMs are not likely to meet all these requirements, but some will. We will continuously search for opportunities to expand the range of options for participation in eligible APMs within the contours of the statute.

In keeping with the statute, it is our intent to align the MIPS and APM components of the new payment system to the extent feasible, thus allowing maximum flexibility for physicians and other clinicians who are not yet ready for eligible APMs to participate in MIPS and then migrate to eligible APMs when they are ready. As we move forward with MACRA implementation, we will continue to gather and incorporate feedback from stakeholders as we promote additional physician-focused APMs. We look forward to addressing important issues around eligible APM participation through our proposed rule later this Spring, and we will keep physicians and other clinicians updated throughout the rulemaking process.

6. **Building off the efforts to align quality measures, has CMS done any modeling if commercial payers are engaged in value based products and payment arrangements?**

    - **Would CMS be open to counting risk based commercial models to a providers APM threshold?**

    - **Do you envision that Medicare Advantage would or could count towards a providers APM threshold?**

Answer: Beginning in 2019, under MACRA, as an alternative to participation in the Merit-based Incentive Payment System, clinicians ("eligible professionals") can receive a 5 percent incentive payment for participation above a specified threshold amount in certain types of Alternative Payment Models (APMs). For the first two years, incentive payments are based on participation in Medicare APMs. However, starting in 2021, under the law clinicians can receive the incentive payment through a "combination all-payer and Medicare payment threshold option." We believe this is an important option that will reward commercial plans' and clinicians' value-based payment arrangements and further encourage clinicians and commercial plans to develop new APMs. We plan to provide further specifications on our proposal for the combination all-payer and Medicare payment threshold option in the forthcoming proposed rule implementing the payment provisions in MACRA. In addition, MACRA requires that CMS submit to Congress a report on exploring the feasibility of the use of APMs in Medicare Advantage.

7. The Merit Based Incentive Program (MIPS) attempted to respond to criticisms that quality measures were being applied to physicians in a one size fits all manner with practices being judged on measures complexly irrelevant or inapplicable to their practice. What is CMS doing to further the Congressional intent of the statute and can you describe how MACRA provides flexibility for providers to be judged on quality measures relevant to their unique practice or specialty?

Answer: MACRA combines three existing quality programs– the Physician Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare Electronic Health Record Incentive Program – into one, aligned new program, the Merit-based Incentive Payment System (MIPS) beginning with payments in 2019. Physicians and other clinicians will be evaluated under MIPS based on a single composite performance score, which will factor in performance on four weighted categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified electronic health record (EHR) technology. We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population.

8. MACRA made important reforms to how quality measures can be more quickly incorporated into Medicare by allowing the Secretary to work with provider and physician groups on validating and adopting quality measures that may not yet be endorsed. Can you speak to this new flexibility and how CMS is approaching the ability for this enhanced collaborative relationship with providers on quality measurement?

Answer: Our goal at CMS is to ensure clinicians have the ability to use clinical quality measures that are evidence-based, right for their practice and their patients, and align with quality improvement goals. In implementing MACRA, CMS will use the rulemaking process to establish an annual list of MIPS quality measures. This list will include, as applicable, quality measures from existing CMS quality programs: the Physician Quality Reporting System, the Value-Modifier, and the Medicare EHR Incentive Program. In addition, CMS will use the annual "Call for Measures", established by the law, to request that eligible professional organizations and other relevant stakeholders identify and submit quality measures to be considered for selection in the annual list of quality measures and to identify and submit updates to the measures on such list. We believe the process to gather input from eligible professional organizations is an important way to bring new measures into the program and provide measure options for clinicians.

CMS is also working to partner with third-party organizations to collect and report quality measurement data for purposes of MIPS. For example, MACRA encourages the use of certified electronic health record (EHR) technologies and Qualified Clinical Data Registries for reporting quality measures. Measures developed from electronic data sources such as EHRs, as well as from QCDRs, draw from a rich set of clinical data and can reduce data collection and reporting burden while supporting more timely performance feedback to clinicians than is possible through traditional claims-based measures.

9. In order to improve patient outcomes and enhance quality of care, the Merit-Based Incentive Payment System (MIPS) incorporates patient engagement features. The RFI issued in October regarding Section 101 of MACRA did not request comment on patient engagement and self-management assessment. There is a direct connection between patients taking an active role in managing their health conditions and improved outcomes especially when providers coach patients in a customized manner to encourage better self-management. National and international use of patient self-management assessment measures that are validated and extensively peer-reviewed and paired with interval level self-management intervention techniques have repeatedly resulted in enhanced health outcomes and reduction in unnecessary utilization. As CMS develops MIPS, will it direct providers to rely on an empirically validated, interval level, patient self-management assessment tool to determine a beneficiary's self-management capabilities?

Answer: CMS is committed to engaging with all stakeholders, including patients and caregivers, in implementing this important legislation. In CMS's calendar year 2016 Medicare physician fee schedule proposed rule, we solicited comments regarding implementation of certain aspects of the Merit-based Incentive Payment System (MIPS) and broadly sought comments from the public on the topics in MACRA. Further, in December 2015, CMS, in conjunction with the Office of the National Coordinator for Health Information Technology, issued an RFI to assess policy options that could improve the effectiveness of the certification of health information technology and specifically the certification and testing of EHR products used for the reporting of quality measures. We are currently in the process of reviewing and incorporating the feedback we received, and we anticipate releasing a proposed rule, including a 60-day comment period, this Spring.

In addition, to understand and measure patient and caregiver experience of care, CMS implements patient experience surveys across multiple programs and settings of care. These surveys ask patients (or in some cases, their families or caregivers) about their experiences with healthcare providers and address topics for which patients are the only or best source of information, such as whether the person was treated respectfully. CMS will continue to develop new patient experience surveys to ensure that these important measures of quality encompass all care settings and providers (e.g., specialists). As noted in our draft Measure Development Plan, CMS will also refine existing patient experience surveys based on stakeholder feedback to incorporate additional topics that are important to patients and families/caregivers (e.g., knowledge, skill, and confidence for self-management and whether the provider acted in accordance with the person's preferences; participation of family members in care discussions or electronic communications; accurate documentation of family members who are authorized decision-makers). CMS will explore incorporating an assessment of cultural competency and perspectives of minority and vulnerable populations (e.g., individuals with limited English proficiency, low health literacy, mobility impairments or other disabilities). In addition, CMS will consider measurements for the physician practice of using tools to assist patients in assessing their need for support for self-management as we move forward in drafting our proposed rule. CMS will balance the effort to obtain important information with the need to minimize burden to patients and clinicians in implementing and responding to the surveys. As we move forward under MACRA, we will be sharing details and inviting comment as part of the rulemaking process this Spring.

10. One of the major challenges facing measure developers is getting quality measures approved by a consensus based organization. MACRA created new flexibilities to encourage measure development and create a direct line for those society developed measures to CMS. Yet, CMS' proposal in their draft Quality Measure Development Plan would require measures that are not NQF-endorsed to align with NQF requirements for its consensus review process. This action seems to undercut the flexibility provided under MACRA. Can you speak to this?

Answer: For measures that are not endorsed by a consensus-based entity, MACRA requires that the measures have a focus that is evidence-based. The law, however, does not define evidence-based or specify how to evaluate the evidence. The use of a consistent set of criteria for evaluating evidence will ensure that measures developed for use in CMS programs are rooted in strong evidence.

As discussed in the draft Measure Development Plan, CMS plans to use the rating criteria established by NQF to evaluate the quality, quantity, and consistency of the evidence for the development of quality measures included in this plan. For measures that are not consensus-endorsed, CMS will ensure that each measure is evidence-based and in alignment with NQF requirements for the consensus review process. This helps to ensure that measures are evidence-based, reliable, and valid. CMS also plans to require that measure developers submit a well-crafted business case for a measure concept that includes a thorough review of evidence.

We believe that it is important to streamline the process for measure development and are working to do this. At the same time, an evidence-based focus is important for evaluating new measures. We received many comments from stakeholders on the Measure Development Plan, and we will take them into consideration as we develop the final plan.

11. Section 102 of MACRA authorizes $75 million to be used over five years, beginning with fiscal year 2015, to expand and enhance existing measures and to develop new measures to fill performance gaps. Has CMS allocated any of this funding, and if not, why not?

Answer: MACRA provides CMS with $15 million annually from FY 2015 to FY 2019 for development of quality measures to support the Merit-based Incentive Payment System and Alternative Payment Models. To meet the requirements of the statute, CMS posted a draft Measure Development Plan on its website on December 18, 2015, with a public comment period through March 1, 2016. The final plan will be posted in May, followed by updates thereafter as appropriate. This plan will be used to guide the priority areas for measure development.

CMS recognizes the importance of measure development as we work to implement the provisions of MACRA. The process of preparing a measurement proposal concept, seeking bids, and assessing competitive bids will soon be underway. CMS has actively engaged with specialty societies to learn about their interests in the funding and is synthesizing the results of these engagement sessions in order to allocate funding in a way that meets the needs of these organizations and adheres to statutory requirements.

12. What, if any, analysis has CMS conducted as to whether or not existing quality programs (including both value based payment arrangements as well as Physician Quality Reporting System PQRS) have had a meaningful effect on quality improvement?

- **Can you speak to any savings these efforts have generated in addition to quality improvement?**
- **Do you have any information in this regard broken down by medical specialty?**
- **If so are there certain specialties that are notable in their work to meaningfully improve quality?**

Answer: In January 2015, the Administration announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients. Earlier this year, the Administration announced that it has already reached its first goal ahead of schedule: an estimated 30 percent of Medicare payments are tied to alternative payment models (APMs), and millions of Medicare patients are benefitting from better coordinated and improved quality of care. Ultimately, this shift towards quality and value will help patients receive, and doctors and other clinicians provide, the best care possible. We are already seeing national trends in health care improvements that are promising and likely a combined result of our efforts:

- There has been a 17 percent reduction from 2010 to 2014 in the number of hospital acquired conditions, such as pressure ulcers, infections, and avoidable traumas, representing over 87,000 lives saved and $20 billion in cost savings.[1]
- Between April 2010 and May 2015, an estimated 565,000 readmissions were prevented across all conditions, compared to the readmission rate in the year prior to the passage of the Affordable Care Act (April 2009 to March 2010). That's 565,000 times that a patient didn't have to experience an extra hospital stay.[2]
- Accountable Care Organizations (ACOs) continue to show promising results. Last fall, CMS released the 2014 quality and financial performance results for Medicare Shared Savings Program ACOs who started the program in 2012, 2013, and 2014. Ninety-two Shared Savings Program ACOs held spending $806 million below their targets and earned performance payments of more than $341 million as their share of program savings. The results also showed that Shared Savings Program ACOs that reported on quality in both 2013 and 2014 improved on 27 of the 33 quality measures, including patients' ratings of clinicians' communication, beneficiaries' rating of their doctors, screening for tobacco use and cessation, screening for high blood pressure, and Electronic Health Record use. Shared Savings Program ACOs also outperformed group practices reporting quality on 18 out of 22 measures.
- Pioneer ACOs are early adopters of coordinated care and tend to be more experienced, have an established care coordination infrastructure, and assume greater performance-based financial risk. These ACOs showed continued strong performance and improvement across financial, quality of care, and patient experience measures. During 2014, Pioneer ACOs generated total model savings of $120 million and improved the

[1] http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2014.html
[2] http://www.hhs.gov/blog/2016/02/24/reducing-avoidable-hospital-readmissions.html

average performance score for patient and caregiver experience in 5 out of 7 measures compared to Performance Year 2, suggesting that Medicare beneficiaries who obtain care from a provider participating in a Pioneer ACO continue to report a positive experience.

Overall, in performance year 2014, Medicare ACOs in the Pioneer ACO Model and the Shared Savings Program have resulted in combined total net savings of $411 million. Savings in the Pioneer ACO Model coupled with improved quality of care led the independent CMS actuary to certify that, as tested in the first two years, the model was eligible for expansion in accordance with the requirements of section 1115A.

Although savings broken out by specialty are not available, as described above, we have seen gains through a broad spectrum of models and value-driven initiatives. We expect these gains will continue to increase over the course of the year, including among bundled payment models within specialty care areas, with the start of the Comprehensive Care for Joint Replacement model and the Oncology Care Model. Ultimately, this shift towards quality and value will help patients receive, and doctors and other clinicians provide, the best care possible.

Every year, CMS issues a Physician Quality Reporting System (PQRS) Experience Report, which has provided data and trends on participation in PQRS since the beginning of the program. The participation rates have increased steadily since it first began in 2007, and a wide array of specialists participate. More specialty-specific quality measures are added to the program each year, and will continue to be added in future years under the Merit-based Incentive Payment System (MIPS), giving specialists the opportunity to report measures that are meaningful to them and pertain to their practice of medicine. We believe that the PQRS program has strengthened the focus on quality and provided clinicians with information they can use to improve.

13. As you know, failure to appropriately apply risk adjustment can inappropriately penalize providers who care for high risk or complicated populations which is why MACRA allowed for a professional to see their MIPS score adjusted – what are your thoughts on the successful implementation of risk adjustment given CMS's experience with other risk adjustment methodologies?

Answer: Equitably evaluating provider performance for outcome measures requires careful consideration and evaluation of associated patient risk factors. Specific to risk adjustment, CMS is participating in a National Quality Forum (NQF) pilot project to evaluate incorporation of sociodemographic factors into risk-adjustment models. In addition, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research on this issue, as directed by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. CMS has been collaborating closely with ASPE on the implementation and analyses of this research, and the first of two reports to Congress are expected to be issued by October 2016.

Furthermore, CMS is promoting collaboration among measure developers in the development of risk-adjustment methodologies. The development and expansion of the National Testing Collaborative (NTC) should also increase the availability of data to identify and test data elements for incorporation into risk-adjustment models. The NTC is an HHS initiative sponsored jointly by CMS and the Office of the National Coordinator. The goal of the collaborative is to

expand and improve measure development and testing by incorporating earlier and more frequent engagement across stakeholders through all phases of measure development.

14. We have heard from physicians and physician practices that were previously successful with PQRS but who have been marked as PQRS failures in 2016 and are receiving a penalty. Many are reporting they do not know why. Can you explain why there appears to be such a high failure rate with PQRS in 2016?

- **Have you looked to see how many previously successful PQRS reporters were judged to have failed this year?**

Answer: The payment adjustment of -2.0 percent under PQRS for 2016 is based on reporting quality measures during a 2014 performance period. The 2014 PQRS Experience Report will be issued in the next few months, which will provide data on the number of professionals who successfully participated in the program in 2014, as well as those who are subject to the -2.0 percent payment adjustment. For those professionals who did not meet the reporting requirements in 2014, one of the reasons may be that these requirements were more rigorous in 2014 as compared to those in 2013, which was the first performance period for application of the negative payment adjustment. In this first year, the criteria were established to give professionals new to the program the opportunity to learn how to report under PQRS, and professionals were only required to report one measure. In 2014, the requirements increased to require successful reporting of three quality measures.

We continue to examine and redesign the submission process and mechanisms for reporting to reduce burden and make these processes user-centered and responsive. We are also continuing to provide targeted outreach, education materials and national trainings with the goal of allowing all professionals to be successful participants. We will continue to do this and strengthen our efforts as we move forward with the last two years of the PQRS program and as we transition to MIPS.

15. How do you envision providers will be able to document, report or attest to their participation in or completion of clinical practice improvement activities?

Answer: CMS is committed to finding methods for providers to document the fulfillment of their efforts in each of the categories that will be evaluated under the Merit-based Incentive Payment System (MIPS), including clinical practice improvement activities that will be as efficient as possible and keep provider burden to a minimum. As we move forward under MACRA, we will be sharing details and inviting comment as part of the rulemaking process this Spring.

16. What process will CMS create for physician specialty societies to create and/or propose Clinical Practice Improvement Activities? Do you intend to require participation in certain activities?

Answer: The clinical practice improvement activities performance category of the Merit-based Incentive Payment System (MIPS) is required to include at least the following subcategories (to which the Secretary may add):

1. Expanded practice access
2. Population management
3. Care coordination
4. Beneficiary engagement
5. Patient safety and practice assessment
6. Participation in an Advanced alternative payment model

We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population.

We know that physicians and other clinicians may need assistance in transition to the Merit-based Incentive Payment System (MIPS) and we want to make sure that they have the tools they need to succeed in a redesigned system. In addition, Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as regional extension centers and regional health collaboratives to offer guidance and assistance to physicians and other clinicians. The technical assistance is to focus on the performance categories under MIPS, including the meaningful use of certified electronic health record (EHR) technology category, helping to make it as seamless as possible for these clinicians and practices to comply with MIPS requirements and helping interested practices transition to implementation of and participation in an alternative payment model. We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance.

In addition to the MACRA funding, in September 2015, CMS awarded $685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and spend dollars more wisely. The Transforming Clinical Practice Initiative is one of the largest federal investments designed to support physicians and other clinicians in all 50 states through collaborative and peer-based learning networks. As with all major implementations, CMS continually assesses resource needs.

As we move forward under MACRA, we will be sharing details and inviting comment as part of the rulemaking process this Spring.

17. Does the agency intend to evaluate the impact of the value modifier program on small practices and solo practitioners in time to inform how resource use will be applied to MIPS?

Answer: The Value Modifier (VM) will apply to physicians in small practices (less than 10 eligible professionals) and physician solo practitioners for the first time in 2017. Since this is the first year that these professionals will be subject to "quality tiering" under the Value Modifier, they will be held harmless during this year from any downward adjustments due to poor

performance on quality and cost measures. The performance period for the 2017 VM payment adjustment year is 2015. As the program is phased in for these small groups and solo practitioners, we continue to consider performance measurement and the lessons learned to inform future policy development under MIPS as well as refinements to the VM in its remaining years. For example, last year in the 2016 Physician Fee Schedule final rule, based on an updated reliability analysis, CMS made a revision and finalized a policy not to apply the 30-day all cause readmission measure to solo practitioners and small practices with less than 10 eligible professionals under the VM. In addition, CMS plans to issue an annual Value-based Payment Modifier Program Experience report. The first one was issued in June 2015, which analyzed the results for the first year of the program. We expect this report to examine characteristics of group practices and their corresponding performance under the Value Modifier.

18. MACRA allows any performance category that a physician, group or specialty could not realistically succeed in to be reweighted. Will CMS consider re-weighting the resource use category until there is more consensuses on the best means by which to evaluate resource use? Does CMS intend to have issues surrounding resource use application settled by implementation? How does CMS anticipate transitioning from the measures under the value based modifier to the use of episode groups?

19. As outlined in the law, the HHS Secretary can incorporate Part D drug spending as part of the resource use component of MIPS, to the extent it is feasible. The current resource use metrics only account for spending on physician administered drugs paid under Part B. Some physicians sometimes have the option to prescribe either a Part B or a Part D drug for a given condition. Since the decision usually comes down to patient choice, one provider may treat a patient with a Part B drug while another rheumatologist treating a patient with the same indications and risk factors could just as easily choose a Part D drug. Under CMS' current resource use methodology, the patient who opted for the Part B drug would appear more costly than the patient who opted for the Part D drug, which would translate into higher resource use and potential financial penalties for the treating physician. Can you elaborate on this situation and how patient choice and the practice of medicine will not be impacted by this provision? Will the proposed rule speak to how CMS is planning to address resource use when it comes to physician-administered and self-administered medications? Has CMS come to a conclusion on how it can incorporate Part D drugs in resource use measurement under the new MACRA programs?

Answer 18 & 19: CMS issued a Request for Information that invites feedback on many questions related to resource use, including how Part D drug costs should be incorporated into MIPS. The feedback we received will help to inform our proposed rule, which will address many critical aspects of MACRA implementation. As we move forward, we will be sharing details and inviting comment as part of the rulemaking process.

20. Can you update us on CMS' and more broadly the Department of Health and Human Services efforts to implement the December 18, 2018 deadline for EHR interoperability imposed by MACRA?

Answer: The Office of the National Coordinator for Health Information Technology recently released "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap," which describes the milestones, calls to action, and commitments to be achieved by 2017 in support of this goal.[3]

21. When Congress enacted the "Protecting Access to Medicare Act of 2014" (P.L. 113-93), which I am proud to say I sponsored, one of our goals was to promote evidence-based care by utilizing appropriate use criteria for certain advanced diagnostic imaging services. In so doing, we wanted to ensure these provisions did not have an unintended consequence of delaying care for patients who sought medical attention in an emergency department until after it was determined that they did not have an emergency medical condition (as defined in section 1867(e)(1)). This exception not only covers individuals with an identified emergency medical condition, but also the applicable imaging service ordered to determine whether or not the individual has an emergency medical condition.

22. What is your agency doing to make sure that the rules being promulgated in regard to this section of P.L. 113-93 are compatible with our intent? Can you assure me that the appropriate use criteria exception will cover the medical screening exam as well as patients with an emergency medical condition?

Answer 21 & 22: We look forward to addressing these issues in upcoming rulemaking.

Section 218(b) of the PAMA directed CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. We believe the goal of this statutory AUC program is to promote the evidence-based use of advanced diagnostic imaging to improve quality of care and reduce inappropriate imaging services. AUCs are defined as criteria that are evidence-based (to the extent feasible) and assist professionals who order and furnish applicable imaging services to make the most appropriate treatment decision for a specific clinical condition for an individual.

There are four major components of the AUC program required, each with its own implementation date: (1) Establishment of AUC by November 15, 2015; (2) mechanisms for consultation with AUC by April 1, 2016; (3) AUC consultation by ordering professionals and reporting on AUC consultation by furnishing professionals by January 1, 2017; and (4) annual identification of outlier ordering professionals for services furnished after January 1, 2017. In the recent Calendar Year 2016 Physician Fee Schedule (PFS) final rule, we primarily addressed the first component—the process for establishment of AUC, along with relevant aspects of the definitions.

PAMA provides for certain exceptions to the AUC consultation and reporting requirements including in the case of certain emergency services, inpatient services paid under Medicare Part A, and ordering professionals who obtain a hardship exemption. We did not include proposals to implement these exceptions in the CY 2016 PFS rule. It is important that we first establish through notice and comment rulemaking the process by which applicable AUC will be specified

[3] https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf

as well as the CDS mechanisms through which ordering providers would access them. We anticipate including further discussion and adopting policies regarding the AUC program requirements primarily in the CY 2017 and CY 2018 PFS rulemaking cycles. Therefore, we do not intend to require that ordering professionals meet this requirement by January 1, 2017.

Given the complexity of the program to promote the use of AUC for advanced imaging services, we believe it was imperative to consult with physicians, practitioners and other stakeholders in advance of developing proposals to implement the program. And we will take into consideration the issue you raised as we work on implementing the AUC program.

The Honorable Michael C. Burgess

1. **What is CMS doing to ensure that there are alternative payment model options for physician groups looking for options that are not built on fee-for-service platform but that do not require the massive financial investment of say, an ACO?**

Answer: MACRA established a particular definition of alternative payment models (APMs) and established what qualifies as an "eligible APM," for purposes of exempting eligible professionals from the Merit-based Incentive Payment System (MIPS) and allowing eligible professionals to receive a special incentive payment as a qualifying APM participant. While creating this new category of eligible APMs provides for promising incentives for a growing number of eligible professionals in the future, we expect the initial years to be ones of development as we apply lessons learned and continue to refine the program. We will continuously search for opportunities to expand the range of options for participation in eligible APMs within the contours of the statute. In keeping with the statute, it is our intent to align the MIPS and APM components of the new payment system to the extent feasible, thus allowing maximum flexibility for physicians and other clinicians who are not yet ready for eligible APMs to participate in MIPS and then migrate to eligible APMs when they are ready. As we move forward with MACRA implementation, we will continue to gather and incorporate feedback from stakeholders as we promote additional physician-focused APMs. CMS looks forward to receiving recommendations for new physician-focused payment models made by the Physician Focused Payment Model Technical Advisory Committee (PTAC).

2. **A goal of MACRA, as well as a major provision of 21st Century Cures, is to deal with the inexcusable lack of interoperability between electronic health record systems. How could CMS potentially restructure the EHR-meaningful use program to ensure that this component of MIPS is more flexible, and is tailored to the needs of specialty practices?**

Answer: As CMS moves forward with implementation of MACRA, we are committed to building a program that fulfills the goals of advancing quality and value while being adaptive to the needs of each clinician's individual practice and patient population.

In particular, we have been working side by side with physician and consumer communities and have listened to their needs and concerns about the Medicare Electronic Health Record Incentive Program for eligible professionals as we transition it to the Merit-based Incentive Payment

System (MIPS). This work will be guided by several critical principles that promote better care for Medicare beneficiaries:

1. Rewarding providers for the outcomes technology helps them achieve with their patients.
2. Allowing providers the flexibility to customize health IT to their individual practice needs. Technology must be user-centered and support physicians.
3. Leveling the technology playing field to promote innovation, including for start-ups and new entrants, by unlocking electronic health information through open application programming interfaces (APIs) – technology tools that underpin many consumer applications. This way, new apps, analytic tools and plug-ins can be easily connected to so that data can be securely accessed and directed where and when it is needed in order to support patient care.
4. Prioritizing interoperability by implementing federally recognized, national interoperability standards and focusing on real-world uses of technology, like ensuring continuity of care during referrals or finding ways for patients to engage in their own care. We will not tolerate business models that prevent or inhibit the flow of data necessary to meet the needs of the patient.

3. We have heard concerns regarding the current set of resource use measures used under the Value-based Payment Modifier. Some have argued that they hold physicians accountable for care provided outside of their control, that the measures focus on conditions and diseases that are irrelevant to many specialists, or they are based on total Part A and Part B costs, which is more appropriate for hospital measurement. What steps is CMS taking to ensure the availability of a more relevant and accurate set of resource use measures in time for the first year of MIPS? If CMS is unable to develop additional measures on time, is there a contingency plan to ensure specialists are not inappropriately dinged?

Answer: CMS issued a Request for Information that invites feedback on many questions related to resource use measures, including whether additional resource use measures should be considered and how resource use should apply to providers in MIPS for whom there may not be applicable resource use measures. The feedback we are receiving will help to inform our proposed rule, and we look forward to receiving additional feedback from stakeholders as part of the rulemaking process.

4. MACRA created a new category within the MIPS payment system called Clinical Practice Improvement Activities. The idea behind this category was to reward physicians for quality improvement activities that they might already be undertaking but not being acknowledged for such as continuing medical education, expanded office hours and the use of clinical data registries. Does CMS plan to recognize a wide variety of clinical practice improvement activities or focus on a more narrow set?

Answer: The clinical practice improvement activities performance category of the Merit-based Incentive Payment System (MIPS) is required to include at least the following subcategories (to which the Secretary may add):

1. Expanded practice access
2. Population management
3. Care coordination

4. Beneficiary engagement
5. Patient safety and practice assessment
6. Participation in an Advanced alternative payment model

We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population.

We know that physicians and other clinicians may need assistance in transition to the Merit-based Incentive Payment System (MIPS) and we want to make sure that they have the tools they need to succeed in a redesigned system. In addition, Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as regional extension centers and regional health collaboratives to offer guidance and assistance to physicians and other clinicians. The technical assistance is to focus on the performance categories under MIPS, including the meaningful use of certified electronic health record (EHR) technology category, helping to make it as seamless as possible for these clinicians and practices to comply with MIPS requirements and helping interested practices transition to implementation of and participation in an alternative payment model. We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance.

In addition to the MACRA funding, in September 2015, CMS awarded $685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and spend dollars more wisely. The Transforming Clinical Practice Initiative is one of the largest federal investments designed to support physicians and other clinicians in all 50 states through collaborative and peer-based learning networks. As with all major implementations, CMS continually assesses resource needs.

As we move forward under MACRA, we will be sharing details and inviting comment as part of the rulemaking process this Spring.

The Honorable Leonard Lance

The spirit and intent of MACRA emphasizes working with and learning from stakeholders in the medical community who are developing alternative payment models and those participating in these new payment models. In particular, medical specialty societies can play an important role, as they lead the development of guidelines and quality metrics in their areas of medicine and increasingly are working to develop alternative payment models.

1. **Can you describe for the Committee how are you planning to work with specialty organizations/societies in developing alternative payment models to ensure that MACRA implementation is flexible enough and meaningful to allow specialists from across medicine to fully participate?**

Answer: It is vital to engage partners who are also committed to, and have a stake in, improving our health care system, including patients, providers, payers, government, and businesses. This is why we helped launch the Health Care Payment Learning and Action Network (LAN) in March 2015 to bring together stakeholders in the public and private sector to accelerate adoption of value-based payments and alternative payment models (APMs). More than 4,800 patients, insurers, providers, states, consumer groups, employers, and other partners joined the LAN and over 50 organizations have made commitments to payment transformation, including health plans, provider organizations, consumer groups, and state governments. The LAN is working to identify areas of agreement around movement to APMs and is collaborating to generate evidence, share best practices, and remove barriers to success. Just one example of the LAN's work is the development of a detailed framework for APMs, which can be used to describe and measure progress in the adoption of APMs across the U.S. health care system. This framework was released in January 2016 and is only the first step of the LAN's efforts, which are now focused on patient attribution, financial benchmarking, and clinical episodes, among other topics. This example shows that CMS, working with a multitude of partners through the LAN, can help the health care system meet or exceed the Medicare goals for value-based payments and APMs.

In addition, through MACRA, Congress established a new independent advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC meets on a periodic basis to review physician-focused payment models submitted by individuals and stakeholder entities and prepare comments and recommendations on proposals that are received, explaining whether models meet criteria for physician-focused payment models. The 11 members of the PTAC, who were appointed by the Comptroller General, are experts in physician-focused payment models and related delivery of care, including researchers, practicing physicians, and other stakeholders. The first PTAC meeting was held on February 1, 2016, and presentations from the meeting are available online. CMS looks forward to receiving recommendations for new physician-focused payment models. We will need stakeholder engagement with the PTAC, including physicians and other clinicians, to suggest well designed, robust models that could meet the statutory criteria to be an eligible APM.

2. **It is my understanding that the radiation oncology specialty society has developed models related to breast cancer and palliative care, and they have several more models in the works. Likewise, other radiation therapy stakeholders are developing and testing new models. I think it's important for CMMI to work closely with medical specialties and other stakeholders. Can you describe how you plan to engage radiation oncologists and the broader physician specialty community in the development of these new models for cancer care?**

Answer: The Center for Medicare and Medicaid Innovation (CMS Innovation Center) has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system. Efforts include developing new payment and delivery models designed to

improve the effectiveness and efficiency of specialty care. Among those specialty models is the Oncology Care Model, an innovative new payment model for physician practices administering chemotherapy. Under the Oncology Care Model (OCM), practices will enter into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients. CMS is also seeking the participation of other payers in the model. This model aims to provide higher quality, more highly coordinated oncology care at a lower cost to Medicare.

The Innovation Center is actively seeking ideas from the public, including specialty physicians and societies, on how care can be delivered and paid for in ways that will lower the total costs while improving quality. Ideas may be submitted by visiting our website at: https://innovation.cms.gov/Share-Your-Ideas/index.html.

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The Honorable Renee Ellmers

1. **Does the Department have the authority it needs to ensure that successful participation in the Meaningful Use program and use of technology certified for the Meaningful Use program will enable success in value-based payment, or does the Administration need additional authorities from Congress?**

    - **If additional authorities are needed, what are they?**

Answer: The Department of Health and Human Services proposed four new legislative authorities for the Office of the National Coordinator in the President's FY 2017 Budget that, if enacted, would improve HHS' ability to facilitate information flow between providers. We have identified opportunities to improve market transparency and reduce information blocking, advance common standards, improve safety, and advance opportunities to support data sharing that are included in our proposals. We believe these proposals strike the right balance between leadership and coordination and will allow us to move these important goals forward to benefit patients, consumers, and providers across the country.

2. **Similarly, do you interpret the MACRA statute, or HITECH for that matter, to enable CMS to manipulate the construct of the Meaningful Use Program to no longer be all-or-nothing for both doctors and hospitals? Or only doctors?**

    - **If only for doctors, how do you account for challenges the potential discrepancies in the Program's construct for doctors and hospitals can pose?**

    - **Do you need additional statutory authority to make any changes?**

Answer: Our goal is for the Merit-based Incentive Payment System (MIPS) to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population.

In particular, we have been working side by side with physician and consumer communities and have listened to their needs and concerns about the Medicare Electronic Health Record Incentive Program for eligible professionals as we transition it to MIPS. This work will be guided by several critical principles that promote better care for Medicare beneficiaries:

1. Rewarding providers for the outcomes technology helps them achieve with their patients.
2. Allowing providers the flexibility to customize health IT to their individual practice needs. Technology must be user-centered and support physicians.
3. Leveling the technology playing field to promote innovation, including for start-ups and new entrants, by unlocking electronic health information through open application programming interfaces (APIs) – technology tools that underpin many consumer applications. This way, new apps, analytic tools and plug-ins can be easily connected to so that data can be securely accessed and directed where and when it is needed in order to support patient care.
4. Prioritizing interoperability by implementing federally recognized, national interoperability standards and focusing on real-world uses of technology, like ensuring continuity of care during referrals or finding ways for patients to engage in their own care. We will not tolerate business models that prevent or inhibit the flow of data necessary to meet the needs of the patient.

The forthcoming proposed rule will offer more details, and we look forward to receiving and reviewing comments following its release.

While MACRA only modified the meaningful use program for Medicare clinicians, we are continuing to consider what additional reforms may be permitted under the statute for hospitals which could increase alignment with MIPS.

3. **We hope the Department is quickly progressing in their efforts to equip physicians to be successful under the new payment models, either in MIPS or APMs, given that 2017 is the first program year for physicians under MACRA. We hope to see the proposed rules released soon to ensure the industry has the best chance of success in 2017.**

- **I'd like to hear if the Administration believes physicians are equipped with the technology they need to be successful under MACRA. Especially given the ongoing struggles of providers in the Meaningful Use Program and the lack of nationwide interoperability. Will EHRs certified for the Meaningful Use program enable success in the new world of value-based payment?**

- **Does CMS have the technical capacity to administer these new payment policies?**

- **Does CMS need additional resources to successfully administer the MACRA programs?**

Answer: The clinical practice improvement activities performance category of the Merit-based Incentive Payment System (MIPS) is required to include at least the following subcategories (to which the Secretary may add):

1. Expanded practice access
2. Population management
3. Care coordination
4. Beneficiary engagement
5. Patient safety and practice assessment
6. Participation in an Advanced alternative payment model

We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population.

We know that physicians and other clinicians may need assistance in transition to the Merit-based Incentive Payment System (MIPS) and we want to make sure that they have the tools they need to succeed in a redesigned system. In addition, Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as regional extension centers and regional health collaboratives to offer guidance and assistance to physicians and other clinicians. The technical assistance is to focus on the performance categories under MIPS, including the meaningful use of certified electronic health record (EHR) technology category, helping to make it as seamless as possible for these clinicians and practices to comply with MIPS requirements and helping interested practices transition to implementation of and participation in an alternative payment model. We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance.

In addition to the MACRA funding, in September 2015, CMS awarded $685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and spend dollars more wisely. The Transforming Clinical Practice Initiative is one of the largest federal investments designed to support physicians and other clinicians in all 50 states through

collaborative and peer-based learning networks. As with all major implementations, CMS continually assesses resource needs.

As we move forward under MACRA, we will be sharing details and inviting comment as part of the rulemaking process this Spring.

4. **As you know, the "Meaningful Use" program was part of the HITECH Act, which was enacted five years prior to MACRA and the accelerated movement to value-based-payment announced last year by the Department.**

5. **Acting Administrator Slavitt said of the Meaningful Use program, "as it [Meaningful Use Program] has existed, will now be effectively over and replaced with something better." If those changes are being consider by MACRA, can CMS make such changes for the current program year if they are good policy beginning in 2017?**

    - **For example: Can CMS relax the "all or nothing" nature of grading for 2016? Docs in 2016 who try and still fail to be meaningful users will receive a whopping -4% reduction in Medicare revenue in 2018, just as they are trying to get used to reporting as they will need to under MIPS.**

    - **CMS should do everything within its regulatory power to keep providers in the program and not take this hit especially since they have the power to lower the bar in a sense.**

Answer 4 & 5: CMS issued a Request for Information that invites feedback on many questions related to meaningful use, including how to determine the performance score for that category in the Merit-based Incentive Payment System (MIPS). The feedback we received will help to inform our proposed rule, and we look forward to receiving additional feedback from stakeholders as part of the rulemaking process.

CMS shares the goal of ensuring eligible professionals and hospitals are successful in the Electronic Health Record Incentive Programs. We will continue to remain responsive to stakeholder input through our rulemaking efforts, the implementation of MACRA, and are committed to helping providers to realize the opportunities health IT presents in achieving the goals of delivery system reform.

6. **How can docs have faith in MIPS and APMs if they don't believe they can be considered meaningful users of HIT, being that 206,000 doctors were subject to Meaningful Use Penalties in 2016? What can we do to ensure physicians have the best chance possible to be successful in the Program in 2016?**

Answer: We know that physicians and other clinicians may need assistance in transition to the Merit-based Incentive Payment System (MIPS) and we want to make sure that they have the tools they need to succeed in a redesigned system. In addition, Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as regional extension centers and regional health collaboratives to offer

guidance and assistance to physicians and other clinicians. The technical assistance is to focus on the performance categories under MIPS, including the meaningful use of certified electronic health record (EHR) technology category, helping to make it as seamless as possible for these clinicians and practices to comply with MIPS requirements and helping interested practices transition to implementation of and participation in an alternative payment model. We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance.

7. **There's no question that delivery system reform won't be possible without an interoperable healthcare delivery system. What is the Administration doing to advance interoperability? How can the Administration leverage some of the progress that has been made in the private sector to advance interoperability?**

Answer: Interoperability is an important part of efforts to make sure that patients get the right care at the right time. The Office of the National Coordinator for Health Information Technology recently released "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap,"[4] which describes these efforts in detail.

8. **MACRA created a new category within the MIPS payment system called Clinical Practice Improvement Activities. The idea behind this category was to reward physicians for quality improvement activities that they might already be undertaking but not being acknowledged for such as continuing medical education, expanded office hours and the use of clinical data registries. Does CMS plan to recognize a wide variety of clinical practice improvement activities or focus on a more narrow set? Please elaborate on why.**

Answer: The clinical practice improvement activities performance category of the Merit-based Incentive Payment System (MIPS) is required to include at least the following subcategories (to which the Secretary may add):

1. Expanded practice access
2. Population management
3. Care coordination
4. Beneficiary engagement
5. Patient safety and practice assessment
6. Participation in an Advanced alternative payment model

We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population. As we move forward under MACRA, we will be sharing details and inviting comment as part of the rulemaking process this Spring.

[4] https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf

9. Will CMS be able to evaluate certified EHR technology to assure it can meet the goals of the EHR quality assessment so that physicians are not penalized for standards that EHRs cannot yet achieve?

10. Congress envisioned MACRA as a means to provide greater flexibility for physicians and not impose new burdens. What is CMS doing to achieve these goals?

Answer 9 & 10: In particular, we have been working side by side with physician and consumer communities and have listened to their needs and concerns about the Medicare Electronic Health Record Incentive Program for eligible professionals as we transition it to the Merit-based Incentive Payment System (MIPS). This work will be guided by several critical principles that promote better care for Medicare beneficiaries:

1. Rewarding providers for the outcomes technology helps them achieve with their patients.
2. Allowing providers the flexibility to customize health IT to their individual practice needs. Technology must be user-centered and support physicians.
3. Leveling the technology playing field to promote innovation, including for start-ups and new entrants, by unlocking electronic health information through open application programming interfaces (APIs) – technology tools that underpin many consumer applications. This way, new apps, analytic tools and plug-ins can be easily connected to so that data can be securely accessed and directed where and when it is needed in order to support patient care.
4. Prioritizing interoperability by implementing federally recognized, national interoperability standards and focusing on real-world uses of technology, like ensuring continuity of care during referrals or finding ways for patients to engage in their own care. We will not tolerate business models that prevent or inhibit the flow of data necessary to meet the needs of the patient.

11. A recent article published in Health Affairs found that physicians are spending $15.4 billion a year to comply with quality reporting measures that many believe do nothing to improve quality. We know CMS is working on modifying the Meaningful Use requirements, but what is CMS doing to make substantial changes to the problems in the Value Modifier (VM) and Physician Quality Reporting System programs?

Answer: MACRA combines three existing quality programs– the Physician Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare Electronic Health Record Incentive Program – into one, aligned new program, the Merit-based Incentive Payment System (MIPS) beginning with payments in 2019. Physicians and other clinicians will be evaluated under MIPS based on a single composite performance score, which will factor in performance on four weighted categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified electronic health record technology. We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population. We look forward to continuing our efforts to gather stakeholder feedback as we proceed with the rulemaking process this Spring.

12. Current timeframes for the release of feedback reports are too long, as CMS typically provides feedback reports, often fraught with errors, six to nine months after the close of the reporting period. This delay means that physicians are already well into the next reporting cycle and have no opportunity to change their behavior before they are penalized again. MACRA also calls for CMS to provide timely, valid and reliable data. What is CMS doing to provide more rapid cycle and accurate feedback to physicians so physicians can have the ability to act on the information and engage in meaningful quality improvement?

Answer: CMS works with physicians to ensure feedback is meaningful and is delivered in a timely manner. In order to best meet providers' needs, CMS has historically had a 3-4 month provider reporting period following a 12 month performance period. CMS then reviews the submitted data, provides feedback, and makes applicable payment adjustments in as timely a manner as possible.

13. MACRA did include funding for technical support for small and rural practices, but practices of all sizes are already dealing with long wait times on MACRA's hotline, QualityNet, and long turnaround time on questions submitted via email. When practices do receive information back from QualityNet, sometimes unanswered questions remain, or information is difficult for clinicians to understand. What type of support systems does CMS envision having in place to help all providers and practices with the questions they have as MACRA is being implemented? How will CMS ensure that information and feedback provided to clinicians and practices is clear and actionable?

Answer: CMS has embarked on a significant outreach effort to engage our users and the clinical community to both develop the policy proposal as well as determine how, once implemented, the clinical community can participate in these programs successfully. Our listening sessions, focus groups, and direct user research (e.g., sitting with clinicians in their offices) have validated the need for a robust communications, education, and training program. We are developing a program that will provide easily accessible resources for all clinicians, many of which will be on-demand so that clinicians can access these resources when it is convenient for them. These materials will focus on helping clinicians understand the programs and how to participate in them successfully. Therefore, the first goal is providing better, easily accessible, and more actionable information to help users self-service successfully and lessen center volumes. Augmenting these efforts is focused field-based training that targets small, rural, clinicians as well as those in health professional shortage areas that will begin in earnest later this year when the rule is finalized. Additionally, CMS will integrate existing programs such as the Transforming Clinical Practices Initiative that has already recruited over 60,000 physicians and clinicians. Programs such as these and working with our federal partners such as HRSA will be very valuable to reaching and preparing front-line clinicians. CMS will work to constantly iterate and improve the education, training, and technical assistance to learn from real-time experiences and input from frontline providers.

CMS is already engaging with medical societies, associations, registries, vendors and other critical channels to gather communications, engagement, and training recommendations and to

use all relevant channels to provide meaningful and actionable information to clinicians of all specialties, geographic representation, and size. The engagement goals are to identify communication and education needs, to ensure that collectively we are developing resources that will help clinicians transition, to push resources to front-line clinicians, and to gather feedback on what's working and what's not. To accomplish this task, we will be engaging field partners at all levels – national, state/regional, as well as local/county level.

As a part of these efforts, CMS is assessing the current Help Desk/customer service solution and we are exploring options to deliver an experience for our users that results in faster, reliable responses regardless of how they choose to seek support. Additionally we are evaluating methods to create mechanisms that will highlight common inquiries to the helpdesk and utilize them to instruct ongoing communication and outreach efforts, as well as generate web based educational content, with the goal of minimizing the need to contact the Service Center for guidance.

Dr. Conway, earlier this month, HHS announced that it had hit their goal of tying 30% of Medicare payments to alternative payment models. The announcement stated this included those participating in the Medicare Shared Savings Program as well as the Center for Medicare and Medicaid Innovation and listed examples of alternative payment models as Accountable Care Organizations (ACOs), advanced primary care medical homes and new bundled payment models. As of January 2016, CMS estimates that $117 billion out of a projected $380 billion in Medicare fee-for-service payments are tied to alternative payment models.

CMS reports that there are 477 ACOs participating in the Medicare Shared Savings program and the Pioneer ACO program. These ACOs are broken down as Track 1, Track 2 and Pioneer ACOs.

14. Dr. Conway, can you walk me through CMS's calculation of this $117 billion? Which types of ACOs were included in reaching this $117 billion? Track 1 ACOs? Track 2 ACOs? Pioneer ACOs?

Answer: As of January 1, 2016, CMS identified 10 alternative payment models[5] for tracking our progress towards the Administration's goals, including Pioneer ACOs and Track 1, Track 2, and Track 3 of the Medicare Shared Savings Program.

We conducted a three-step analysis to project total estimated APM expenditure for each model.

- Step 1—Number of attributed beneficiaries: Beneficiaries attributed to most models were provided by the model groups using predefined prospective attribution methodologies. Figures were adjusted to account for attrition over the course of the year based on the average historical rates of attrition, where available.

[5] Medicare Shared Savings Program (MSSP), Pioneer ACOs, Next Generation ACOs, Comprehensive End Stage, Renal Disease Care Model (CEC), Comprehensive Primary Care Model (CPC), Multi-Payer Advanced Primary Care Practice (MAPCP), End Stage Renal Disease Prospective Payment System (ESRD PPS), Maryland All-Payer, Medicare Care Choices Model (MCCM), Bundled Payment Care Improvement (BPCI 2-4)

- Step 2—Multiply by annual cost per beneficiary: Expected annual spending for each beneficiary was provided by model teams. Figures were inflation-adjusted using OACT projections of growth in Medicare Part A and B spending in 2016.
- Step 3—Remove beneficiaries who may participate in more than one model: Participants in non-shared savings models can overlap with a shared savings model. Downward adjustment in non-shared savings models were made based on a uniform distribution of shared savings and non-shared savings models.

The proportion of Fee for Service (FFS) payments tied to APMs was calculated by adding the estimated expenditure for each model—found using the three-step process above—and comparing this to total Medicare FFS spending as projected by OACT.

15. If CMS included all types of ACOs into this calculation, does that mean that CMS considers them all alternative payment models that should be qualified to be considered for MACRA bonuses?

Answer: MACRA established a particular definition of alternative payment models (APMs) and established what qualifies as an "eligible APM," for purposes of exempting eligible professionals from the Merit-based Incentive Payment System (MIPS) and allowing eligible professionals to receive a special incentive payment as a qualifying APM participant. Later this Spring, we will release a proposed rule that will further define the criteria for an eligible APM, and we look forward to gathering feedback from stakeholders as a part of the rulemaking process.

The Honorable Gene Green

One of the most important Clinical Practice Improvement Activities in which nuclear cardiologists, as well as other physician specialists, engage is consultation with imaging appropriate use criteria (AUC).

Prior to passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress passed the "Protecting Access to Medicare Act of 2014" (PAMA) which establishes that health care professionals must consult AUC prior to referring a patient for an advanced diagnostic imaging test, such as nuclear imaging, computed tomography and magnetic resonance.

1. **What efforts are being made by CMS to ensure that physicians who fulfill the Medicare AUC Program requirements also receive credit for this activity under the Clinical Practice Improvement Activity component of the Merit-Based Incentive Payment System (MIPS)?**

2. **For many specialists, like nuclear cardiologists and radiologists, MIPS and alternative payment models will center on the performance, interpretation and quality of imaging tests. Has CMS considered how the AUC Program requirements could be fulfilled through the MIPS and APMs rather as a stand-alone program, which would allow for consultation of AUC, the goal of the AUC Program, to be measured against robust quality and resource use metrics?**

Answer 1 & 2: Determining how existing provider requirements will fit into the Merit-based Incentive Payment System (MIPS) is a critical part of our ongoing efforts to implement MACRA legislation. We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population. Within the next several weeks, CMS will release a proposed rule addressing many critical aspects of MACRA implementation, such as details on evaluation of MIPS categories. We look forward to receiving comments as part of the rulemaking process.

The Honorable Elliot Engel

1. **As you know, MACRA included language that afforded the Secretary the authority to develop measures and alternatives to reflect the way non-patient facing physicians practice medicine. These physicians, as you know, do not have regular and direct interaction with patients. How is CMS implementing that provision to enable physicians to comply with the quality programs in the MIPS program**

Answer: The delivery of specialty services, including those provided by non-patient facing physicians, is critical to our health care system. Determining how to evaluate the activities of these providers through the Merit-based Incentive Payment System (MIPS) is a critical part of our ongoing efforts to implement MACRA legislation. We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population. As a part of our Request for Information[6], we sought comment on a number of questions related to MIPS categories for providers who furnish services that do not involve face-to-face interaction with patients. The feedback we receive in response will help to inform our proposed rule, and we will invite additional comments and feedback as part of the rulemaking process.

[6] https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-24906.pdf