May 26, 2016

The Honorable Joseph R. Pitts
Chairman
Energy and Commerce Subcommittee on Health
Washington, DC 20515

Dear Mr. Chairman,

I was honored by the opportunity to testify on behalf of the American College of Physicians (ACP) at the April 19th bipartisan hearing entitled, "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms." I applaud your efforts and those of your subcommittee colleagues in wanting to ensure that MACRA is successfully implemented and for inviting physician stakeholders to take part in the process.

As requested, please find herewith responses to additional questions for the record, as submitted to ACP by the subcommittee on May 13th. We look forward to working with you as implementation of MACRA continues and would be happy to serve as a resource for you, if and when needed.

Sincerely,

Robert McLean, MD, FACP, FACR
Member, Board of Regents

Chair, Medical Practice and Quality Committee
American College of Physicians

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Additional Questions for the Record

The Honorable Joseph R. Pitts

1. Do you believe the threat of the SGR slowed efforts of physician organizations to develop alternative care models? Can you explain?

The inflexible, one-size-fits-all approach to physician payments under the Sustainable Growth Rate (SGR) was arguably a major deterrent to the development of alternative payment models by certain physician organizations, but not all. One can understand how the constant threat of yearly payment cuts of nearly 30 percent under the SGR, over the course of a decade, could overshadow and inhibit any desire for exploration and/or development of new, innovative physician payment models. The American College of Physicians (ACP), however, was at the forefront of the movement to develop and fully integrate the "Patient-Centered Medical Home" model into the health care delivery system, even while contending with the burdens of the SGR system. And, that effort began long before the actual first demonstration project to test the medical home concept was initiated by Congress, under a House Republican majority, in 1996.

A Patient-Centered Medical Home is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. More than a decade ago, ACP began investing countless resources into the medical home concept believing it could serve as one of the most promising models of care delivery in the future; one that would not only provide higher quality care to patients but also reduce costs to the health care system as a whole. Today, this model and its achievements are becoming more and more pervasive throughout the health care system, including its inclusion and prominence within MACRA.

ACP has also been able to develop and facilitate the testing of the Patient-Centered Specialty Practice Model, one that also is now incentivized within the MACRA law—via allowing those who participate the opportunity to receive full credit under the clinical practice improvement activities (CPIA) category of MIPS. This model is one that can serve internal medicine subspecialists, as well as other medical specialists well; however, there are a number of specialties that are still feeling left out in terms of having applicable alternative payment models available to them. Under the previous payment system, which included the consistent threat of SGR-related payment cuts, development of many alternative models was extremely challenging. Therefore, ACP is encouraged that the MACRA law offers greater opportunities for new models to be developed, tested, and ultimately rolled out.

2. Which communication methods have been most effective for making physicians aware of, and prepared for, the changes?

One of the most direct approaches to education for our members is through in-person meetings. ACP's Internal Medicine Meeting 2016 took place here in Washington, D.C. on May

5th to 7th. This meeting, which is held annually, brings together over 6,000 internal medicine physicians from across the country to attend more than 200 scientific sessions. During the 2016 meeting, the College provided MACRA education through several formal lectures and courses, informal briefings in our exhibit hall, press events, and multimedia displays shown throughout the entire conference. Following this meeting, we will provide recorded versions of many of these sessions to our members via our website. Other ACP in-person meetings are held by our chapters. The College has chapters in all 50 states, as well as in the District of Columbia and Puerto Rico, all of which hold meetings each year, generally starting in the Fall. MACRA-focused education and outreach will take place at all of those meetings this year in a variety of forms, including lectures, courses, and multi-media displays.

Beyond in-person meetings, a critical touchpoint for our membership and beyond is via our website, where we have created a MACRA-specific webpage. This website includes links to all of ACP's educational resources on MACRA, as well as practice support resources, and will continue to grow as the MACRA rulemaking progresses.

3. **MACRA provided great flexibility in its effort to streamline the three major physician quality reporting systems. It did this by sun setting and reconstituting them into a single reporting system, The Merit Based Incentive Program (MIPS). This provides CMS an opportunity to reevaluate these programs and make changes to them that furthers the legislation's goals of coordination and ease of reporting. Administrator Slavitt have made comments regarding Meaningful Use for example that appear to recognize this flexibility. What are your thoughts on this flexibility to eliminate duplicity reduce redundancy and increase effectiveness and simplicity in physician reporting?**

ACP very much supports efforts to eliminate redundancy and increase the effectiveness in physician reporting. Starting in 2019, the existing Medicare quality reporting/incentive programs (PQRS, Value Based Modifier, and Meaningful Use) — which vary significantly in terms of measures, data submission options, and payment timelines — will be consolidated into one single quality improvement program, the Merit-Based Incentive Payment System (MIPS**)**, reducing the significant confusion and hassles now associated with the current three separate reporting programs. These separate Medicare reporting programs are not at all clear, transparent, or aligned in terms of performance thresholds that must be met. MACRA changes that and streamlines these programs to provide for more efficient reporting. We expect this will reduce the unnecessary regulatory burdens of complying with three different quality reporting programs, each with their own measures, deadlines, rewards and penalties.

More specifically, with regard to Meaningful Use (MU), the MACRA proposed rule has outlined a number of potential changes, including renaming the program to be the Advancing Care Information category within MIPS. These proposed changes are very encouraging as they seem to address many of the issues that have been raised with MU, such as eliminating thresholds, reducing the pass-fail nature, simplifying the base score reporting, and adding a flexible performance score component. ACP will be evaluating this category, as well as the other

components of the MIPS program, very closely and will likely be recommending additional changes to make further improvements.

Beyond MU, ACP is also appreciative of the simplification and improvements that CMS has proposed for the quality reporting category within MIPS—including reducing the number of required measures from nine to six, better organizing the measures to allow for easier selection of individual measures or a specialty measure set, encouraging outcome measurement, and automatically calculating population measures. We will continue to seek further improvements in this category aligned with our recent recommendations in response to the Draft CMS Measure Development Plan. View ACP's comment letter here.

Further, ACP was strongly supportive of the addition of clinical practice improvement activities (CPIA) to the MIPS program, which allows physicians to receive credit for quality improvement activities that many of them may already be doing—and that contribute to improving care even in advance or outside of an existing quality or resource use measure. ACP appreciates that CMS has proposed to implement this category in a non-burdensome manner, with a lot of options available for selection by physicians.

4. **MACRA, and MIPS specifically, is dependent on timely (ideally as close to real-time as possible) communication related to performance and improvement. However, many feel that current timeframes for the release of feedback reports are too long. This delay means that physicians are already well into the next reporting cycle and have no opportunity to change their behavior. Yet, MACRA rewards physicians who make notable jumps in quality to encourage that behavior. What do you believe CMS should do to provide more rapid and accurate feedback to physicians so physicians can have the ability to act on the information?**

ACP agrees that physicians and other clinicians need to receive timely feedback on their performance—and the MACRA law does call for CMS to shorten the timeframe between performance periods, feedback reports, and subsequent payment adjustments. CMS has been providing feedback to clinicians on their performance via the current Quality and Resource Use Reports (QRURs) that are part of the Value-Based Modifier Payment program (which will soon be incorporated into the MIPS program as the cost component). However, these reports are only provided annually, with some partial information available mid-year. CMS proposes in the MACRA rule to continue to provide performance feedback on an annual basis and "may consider in future years providing performance feedback on a more frequent basis, such as quarterly." As the College noted in commenting on the RFI, CMS should make feedback reports available as frequently as possible, quarterly at a minimum but working toward monthly reports as soon as possible. Receiving data more than six months after it is reported, as is currently done with the QRURs, has little value to physicians and impedes their ability to use the data to make necessary changes to their practice to improve the quality of care for their patients. CMS acknowledges in the proposed rule that "many health care providers are still unaware of these [PQRS feedback reports and QRURs] and/or have difficulty accessing their reports in the portal. Further, we are aware that some health care providers perceive the current reports as complex

and often difficult to understand." ACP urges Congress to provide oversight to ensure that physician stakeholder organizations are given additional opportunities to provide input into the development and improvement of these performance feedback reports to ensure that information that is provided in these reports is timely and includes appropriate drill down data. It will be important that special consideration be given to the limited resources that smaller practices have to analyze the outdated, often confusing data contained in the current reports to minimize the burden placed on these practices and allow them to implement practice improvements. Thorough education of physicians on the availability of these feedback reports including information on how to use and interpret the data to make practice improvements will also be critical.

Additionally, ACP has encouraged CMS to develop a customizable dashboard that eligible clinicians would have available in their system that is refreshed with data from all reporting sources, optimally on a daily basis. CMS can look to what many private payers have already done with dashboards as examples of how to design dashboards that include usable and useful data that is available on demand for physicians. All available information should be available to the eligible clinician by query to an open API. The College is encouraged that CMS proposes in the rule "to initially make performance feedback available using a CMS-designated system, such as a web-based portal; if technically feasible perhaps an interactive dashboard." ACP encourages Congress to work with CMS to ensure that the development and implementation of these feedback tools is done with proper input from physician organizations and in a manner that allows timely end-to-end testing to occur so that problems can be addressed prior to their use.

The College also believes that it will be critical for CMS to include patient-level data in feedback reports and make them accessible from the dashboard. Having access to patient-level data allows clinicians to drill down and determine patients who are outliers and may require additional care or follow-up. Finally, including a list of patients that are attributed to the clinician/practice is important to include in any data made available to physicians.

5. As you may know, telehealth is an issue of great interest to many of our members, including the bipartisan Energy & Commerce telehealth working group. Can the witnesses speak to their thoughts on the role telehealth can and should play in care delivery, particularly in the development of APMs?

ACP supports the expanded role of telemedicine as a method of health care delivery that may enhance patient–physician collaborations, improve health outcomes, increase access to care and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care. The expanded role of telemedicine can be most efficient and beneficial when provided as part of an established, ongoing relationship between a patient and physician. The patient-centered medical home model (PCMH) is ideally suited to providing such a relationship, providing the convenience and tools patients want while reducing the potential for fracturing their continuity of care by seeking episodic care through direct-to-patient sites. It likewise makes sense for alternative payment and delivery system models (e.g.,

PCMHs, ACOs), that are based on value, to have a telehealth waiver (e.g., a waiver of the geographic component of the originating site requirement as a condition of payment for telehealth services) and the ability to choose the most effective and efficient way of providing the service. This waiver should be available to ACOs in all three tracks of the Medicare Shared Savings Program.

6. **Clinical data registries and certified EHRs are envisioned by MACRA as serving as critical reporting mechanisms for providers to interact with the Medicare program. Can you provide your thoughts on implementing these clinical data registries and how ideally both they and EHRs will be able to meet reporting requirements? Would this represent a decrease in administrative burden?**

ACP has partnered with CE City to offer our members the ACP Genesis Registry™, which is a CMS-approved qualified clinical data registry (QCDR) for use with PQRS. As a QCDR, the Genesis Registry can include data from multiple payers, allow for continuous exchange of EHR data and benchmarking, help physicians meet the requirements of Stage 2 MU, and provide meaningful feedback reports to clinicians. This registry currently has more than 30,000 providers using it to attest to MU, and includes all of the 64 e-Measures across all 6 National Quality Strategy (NQS) domains. Calculated measures represent more than 123 million patient records. ACP also offers the PQRS Wizard–a tool that provides a step-by-step approach to help ensure that eligible professionals (EPs) meet all of the data, scoring, and attestation requirements before they submit their PQRS reports to CMS. Both of these registries are critical to ensuring physician and other clinician success in reporting on quality measures, which will continue to grow in importance as MACRA is implemented.

AmericanEHR Partners provides physicians, state and federal agencies, vendors, and funding organizations across the United States with the necessary tools to identify, implement, and effectively use EHRs and other healthcare technologies. This tool was developed by Cientis Technologies and the American College of Physicians and is dedicated to the creation of an online community of clinicians who use information technology to deliver care to Americans. Through education, social media, and the collection of peer contributed data this service organizes information to facilitate optimal decision making. AmericanEHR Partners also includes critically important MU attestation data in an easy-to-read format. Given that MU, and effective use of health information technology, is an ongoing component of both MIPS and APMs, this tool provides an invaluable service to physicians, their care teams, and other stakeholders.

These tools are designed to educate, facilitate and streamline reporting for clinicians, which is one of many steps the College is taking to reduce administrative burdens on clinicians.

7. **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 and its importance to MIPs?**

The College strongly agrees that valid risk adjustment is essential for the success of MACRA implementation. This is true both under the MIPS pathway, within the Cost and Quality components, and within the advanced Alternative Payment Model (APM) pathway as it effects benchmarking, quality calculations, and the adequacy of various up-front (e.g. care management payment under CPC+) and back-end (e.g., MSSP shared savings) payments. As you are aware, the literature reflects the adverse effects of inadequately risk-adjusted payment models. When inadequate risk adjustment occurs, physicians and other healthcare professionals are incentivized to engage in activities that minimize the number of severely ill (e.g., multiple co-morbidities), high cost, and low socioeconomic status patients from their treatment panels. This results in decreased beneficiary access to healthcare services, and exacerbates already existing healthcare disparities. We believe that the current Medicare Hierarchical Condition Categories (HCC) risk adjustment approach is a significant improvement from previously used methodologies. We look forward to the completion of studies being conducted by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) on the issue of risk adjustment for socioeconomic status on quality measures and resource use, and the use of this information to improve further the risk adjustment methodology currently being applied.

- **What have been your personal experiences with other risk adjustment methodologies**?

Regarding my personal experiences with other risk adjustment methodologies, it has been largely in the past year when some of the Medicare advantage plans requested that I review my charting to increase the complexity of diagnostic codes to use in office visits. I had until then not been fully aware of the significance of the use of HCC methodology to help demonstrate the complexity of caregiving to high-risk patients and the importance that that has in our payment methodologies to the Medicare advantage plans and what role that will have going forward in risk adjustment for payments to accountable care organizations.

Overall physicians are extremely under-educated on the importance of this. The challenge is that physicians spend so much time and effort adequately documenting what they're doing and they now need to take even more time and effort to find the right complex diagnostic codes to demonstrate this. It is yet another time-consuming step in many situations depending upon how one's electronic health record is set up.

However, as physicians understand the critical need to truly demonstrate the complexity of the care they deliver in this way, they will be able to better document the work that they are already truly doing. It is yet another educational process.

<u>The Honorable Gus Bilirakis</u>

1. **One area that is addressed by MACRA, but that will require significant guidance by CMS, is physician participation in multiple alternative payment models or APMs. We wanted**

physicians to be able to experiment with different approaches to improving their practices while also recognizing that many APMs being developed by stakeholders are somewhat narrow in focus – centered on a specific disease or condition.

- **Can each of you speak to why it is important to allow physicians to experiment with different quality based payments?**

  MACRA is in fact a welcomed change to the one-size-fits-all SGR payment formula because it opens up new, multiple pathways for better payment and care delivery. And, because MACRA moves us away from the volume-based care of the SGR and fee-for-service towards more innovative models of care focused on value and quality, it is important that clinicians have more choice and flexibility in their Medicare payments. For example, the College is very pleased that MACRA supports PCMHs, through both the MIPS program and as an advanced APM. Under MIPS, "certified" PCMHs qualify for the highest possible score for the clinical practice improvement activities category, which is 15 percent of the total weighted score. MACRA also directs HHS to include PCMHs as an advanced APM, without requiring that they take direct financial risk, as long as they can demonstrate the ability to improve quality without increasing costs, or lower costs without harming quality.

  Along these lines, CMS's announcement of the new *Comprehensive Primary Care Plus* (CPC+) Initiative is particularly important because it potentially will create a pathway for thousands of physician practices to incorporate the PCMH model into their practices and qualify as an advanced APM, or receive higher MIPS scores for practice improvement, as authorized by MACRA. ACP expects to ask CMS to consider other approaches to including PCMHs as advanced APMs with reduced or no risk as soon as is feasible under the law.

  Beyond the PCMH model and the new CPC+ program, it is important for Internal Medicine subspecialists and other specialists to have opportunities to experiment with different alternative payment model options. One of these options is the Patient-Centered Specialty Practice model, which is specifically identified in the MACRA law as qualifying for full credit under the clinical practice improvement category of MIPS. This model should also be considered by CMS as an advanced APM as soon as possible. Subspecialists should also be provided with clear and specific guidance from CMS as to what they will consider as other future advanced APMs. The need for this guidance is time sensitive as many organizations are working to develop and test new models now—and it would be tremendously unfortunate for them to have to re-engineer or re-start their efforts if they are not on the right track. It is also important that CMS seek immediate feedback and input on their advanced APM development guidance from practicing clinicians and specialty societies to ensure that the agency's approach is fully informed of any potential pitfalls or unintended consequences of the guidance that they are providing.

- **Can you speak to past experiences you may have had in managing different payment arrangements? How would you suggest CMS lay a positive foundation for physicians to be laboratories of care delivery?**

Given my practice situation that is mainly straight fee-for-service but with some large contracts now structured to have some shared savings (but really just starting), I really cannot say I am "managing different payment arrangements" yet.

However, I do think a foundation can be laid for physicians to be laboratories of care delivery if different payment arrangements are created in ways to allow alignment of quality improvement work, reducing work/administrative burden, and especially paying for non-face-to-face time (that is one of the greatest issues related to primary care delivery) as well as incorporating chronic care management issues.

At this point, all of those elements are quite disparate. Payment arrangements that unite and align them are critical.

2. **When we talk about payment models, there is a lot of focus on physicians, other providers, and delivery systems reforms improving quality and lowering cost. However, there is another component to the equation and that is patients. Patients will need to be involved and play an important role in helping to ensure these efforts are successful. What are your thoughts on the role patients can play to improve quality and lower costs while helping providers reform their delivery of care?**

In addition to resources aimed at helping clinicians and their practices, via our Center for Patient Partnership in Health Care, the College has also developed information to help patients and their families understand health conditions and facilitate communication between patients and their healthcare team. These resources are organized by condition, including allergies and asthma, diabetes, heart health and many others, and are available in a variety of formats including self-management guides, videos, and one- and two-page topic summaries.

ACP also offers patient care tools to assist doctors in effectively maintaining and enhancing the doctor-patient relationship and has partnered with The Wellness Network are partnering to deliver new patient education programming that will be available via The Wellness Network's Patient Channel, an in-hospital TV network and online portal.