AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

House Energy and Commerce Committee

Subcommittee on Health

Medicare Access and CHIP Reauthorization Act (MACRA) of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms

Questions for the Record

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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?**

   Before Congress approved the MACRA, the health care delivery system emphasized fee-for-service without the appropriate support for value-based care models. Although there are systemic obstacles that hindered delivery reform, repealing the SGR was among many areas of concern.

   The AAFP remains optimistic that MACRA's implementation will foster a transition away from fee-for-service through new alternative payment models, but our message to CMS has been clear: physicians need to have reasonable qualifying standards and as few administrative burdens as possible. Through our work on the patient-centered medical home, family physicians learned that standards for qualifying needed to be manageable and achievable in all practice settings. Also, we learned that physicians who practice in rural and remote areas or small or solo practices usually need additional resources because coordination with other physicians or accessing additional resources can be difficult. The AAFP continues to review and analyze the proposed rule implementing MACRA, but we are growing increasingly concerned by the day about the potentially negative impact this law will have on solo and small group practices. We urge Congress to impress upon CMS that the final regulations should not impose unfair administrative burden and expectations on solo and small practices.

   Also, our physicians face challenges implementing Chronic Care Management code as envisioned by the Centers for Medicare & Medicaid Services (CMS). Medicare payment for this service is intended to encourage care for patients with multiple chronic conditions. Although the goals are laudable, family physicians face administrative challenges in collecting applicable Part B copayments and convincing patients to agree to pay for non-face-to-face services from their family physician. We believe this is an area deserving of immediate Congressional action. Elimination of the beneficiary cost-sharing requirements for the CCM code would substantially improve the use and impact of this important policy that is essential to primary care.

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

   The AAFP has dedicated significant resources to educate our members through online web materials, written materials, blog posts, webinars, conference sessions, and in-person briefings. Our experience is that all these resources are important, but the most valuable way to help prepare members is through as much person-to-person information as possible. We are doing so in many venues to help educate members about MACRA and to answer their questions. The organization is also empowering members to spread the word to other physicians. We will have member education courses available at our annual meeting, called Family Medicine Experience (FMX), which attracts between 3,500 – 4,000 family physicians each year. Organizational experts and leaders are traveling to state chapters for in-person briefings.

   As an organization with over 124,900 members, we will have to evaluate message penetration. Family physicians have very busy schedules with many items competing for

their attention. Our members also work in diverse settings. Therefore, federal agencies will need to supplement and coordinate with the AAFP's outreach efforts.

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?**

   Concerns about administrative burdens have been a threat to patient care and practice viability for many years. During my time as a leader of the AAFP, I have heard from countless members who asked me to reduce the administrative complexity of the Medicare program and reduce, significantly, the administrative burden placed on physicians by our current regulatory structure. I believe that Congress can exercise leadership in this area by encouraging CMS to simplify the process so that physicians can focus on providing the best possible patient care.

   The AAFP supports the consolidating and streamlining of the three reporting programs into the Merit-based Incentive Payment System (MIPS), but we believe several barriers may prevent many members from successfully meeting the MIPS performance measures. The first and most significant barrier is the poorly designed Meaningful Use program – now called the Advancing Care Information program – and its lack of interoperability standards, which prohibit the sharing of patient information in a useful form. Physicians face significant challenges with their EHRs and meeting current Meaningful Use standards. Until the Meaningful Use program's criteria in the advancing care information component of MIPS is improved, and the EHR issues are resolved, it is difficult to foresee a large percentage of physicians—particularly those in small and independent practices—being successful in MACRA programs. EHRs should be a tool for success in a physician's practice, not an obstacle to overcome. Again, we urge Congress to intervene and enact legislation that would require vendors and CMS to create a health information system that worked in the interest of patients and their physicians – not the interest of the vendors who produce and sell these inadequate products to physicians and hospitals.

   As we indicated in our November 2015 letter and February 2016 comment to CMS, the AAFP supports reasonable and achievable quality measures that promote continuous improvement and reflect patient experiences. The AAFP opposes an approach that requires physicians to report on a complex set of measures that do not impact or influence the quality of care they provide to patients. Currently, 61 percent of family physicians have contracts with seven or more payers. Each has its own quality reporting, prior authorization, and appropriate use criteria. The AAFP has strongly urged CMS to streamline, harmonize, and reduce the complexity of quality reporting in the MIPS and APM programs. All measures used must be clinically relevant, harmonized among all public and private payers, and minimally burdensome to report.

   In 2014, the AAFP also engaged in a collaborative effort with CMS, America's Health Insurance Plans (AHIP), and representatives from the patient community to identify and develop a set of core quality measures for primary care physicians. Our collaboration was

supported by the National Quality Forum and the National Committee for Quality Assurance to ensure that our work was adhering to the most recent science and evidence on quality and performance measurement. We are pleased with the preliminary outcomes of the process. The AAFP has recommended in numerous communications that CMS should use the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. Additionally, the AAFP strongly believes CMS should utilize and implement the Core Measure sets agreed to through the Core Measures Collaborative for inclusion in MIPS and APMs.

Although CMS has taken steps to ease burdens in some areas, we are deeply concerned that the regulatory process may inadvertently create addition requirements for physicians. Successful MACRA implementation must include significant flexibility and process simplification. We are especially concerned that the regulations, as proposed, will have an unfair negative impact on solo and small group practices. Congress must communicate with CMS that the final regulations must not unfairly impact these physicians and practices. This message cannot be reinforced enough. We welcome the opportunity to work with CMS and the Committee to ensure that true regulatory flexibility is realized as an integral element of MACRA implementation.

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?**

   For the MIPS to be successful, it is imperative that CMS send timely, accurate, and actionable feedback to physicians. To date, CMS' feedback on the Patient Quality Reporting System, Quality Resource Use Reports, and Value-Based Modifier programs is sent one to two years after the reporting period, thus minimizing its clinical improvement value. It is totally unacceptable for CMS to expect providers to install the most up-to-date technology, report performance date within 90 days after the close of the reporting period, and monitor performance and make improvements in real time while the agency fails to install or develop software and technology that will allow analysis of the data and feedback in a timely manner. If CMS is unable to collect, aggregate, and transmit data in a timely manner to physicians, then how can they expect physicians to improve their quality and efficiency at an accelerated rate. Our members and CMS should be partners in these areas and we need our partner to improve their performance. Absent such action by CMS, the implementation of this rule should be delayed by Congress to allow adequate time for CMS to institute and test these changes.

   A primary care provider's ability to improve performance relies heavily on the availability of timely, accurate and actionable quality and cost data on all physicians and providers who care for their attributed population. Besides managing costs and quality for any referrals, understanding current performance is critical to monitoring improvement and understanding where continuous improvement is needed. It is only when a provider has access to these data that they can be responsible for overall performance.

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?**

   As my written testimony indicates, primary care physicians treat patients across the spectrum and without regard to age, gender, or disease category. In some communities, the family physician is the only physician within hundreds of miles.

   Telehealth could play an important role in helping physicians coordinate health services such as referrals. Also, with established patients, telehealth could support care continuity that is convenient, patient-centered and involves less time and travel, particularly for patients that have multiple, often chronic, conditions.

   Most importantly, telehealth can help increase access to care for patients in rural, underserved areas of the country. Physicians in rural communities and their patients often have limited access to specialists, particularly mental health professionals. Telehealth consultations with psychiatrists, especially child and adolescent specialists, could help enhance patient care. Telehealth could also improve dermatological services. Of course, the value of increased access and convenience is not limited to rural or underserved areas of the country.

   All told, telehealth services have the potential to improve patient outcomes, lower costs, and reduce fragmentation. These are all essential elements of the value-based systems supported within alternative payment models. Ongoing evaluation and study are needed to ensure these potentials become realized.

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?**

   Ultimately, registries should be important tools for improving patient management and reducing administrative burdens. The AAFP encouraged CMS to choose reporting options that require the least burden. Instead of overly focusing on the reporting of quality measures, CMS should keep the focus on a continuous process for clinical improvement.

   Ultimately, Qualified Clinical Data Registry-based (QCDR) reporting may be the least burdensome as work is done "behind the scenes." However, the set -up for a QCDR is time-consuming and a costly investment for the practice. Though the EHR reporting option, in theory, should be less burdensome, practices continue to find it difficult to work with EHR vendors. Also, our members report many concerns with this reporting option. While claims data may be all that is available right now, CMS should pursue pathways that allow for the reporting of clinical data. Despite the lack of a perfect reporting option, CMS should encourage quality reporting focus on care delivery and quality measures, not on the technology used for reporting. We would encourage Congress to place the appropriate pressure on vendors to produce products that allow for this type of performance improvement.

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?**

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

    It is important, when discussing risk adjustment, to recognize that patients cared for by family physicians – especially Medicare patients – are usually complex due to multiple diagnoses, independent of any social determinants of health. Most Medicare patients seen by family physicians have one or more chronic conditions and require intensive primary care services both to manage their current disease state, and to prevent the onset of others. The complexity of the patient should be the first risk adjustment.

    As we indicated in our comment to CMS (42 CFR 414), the AAFP supports reducing health disparities as a part of care delivery and urges CMS to move forward with expanding its risk-adjustment methodology in quality measures to incorporate social and economic factors, such as race, income, education, and region. Risk-adjusting for socioeconomic status ensures the measures are fair and sets the standard for comparison of physician performance by adjusting for factors outside of the physician's control. Not adjusting could lead to misleading conclusions about physician performance. As a result, further disparities in care could be magnified. Through HealthLandscape, the AAFP has developed the Community Vital Signs tool that could assist practices of all sizes to understand the social and economic status of their patient population.

    With a focus on health outcomes, practices will need an infrastructure that supports population health management and risk-stratified care management, which begins with attributing patients to their primary care physician. By identifying panels, physicians, and their care teams can risk-stratify patients based on the individual care and support needs of each patient, thereby allowing for a current state assessment of the health of the population and a gap analysis of resource needs. For those patients with complex or multiple conditions, the primary care physician and care team will need to collaborate with any specialists, care provider, or community organization providing care to the patient to ensure ongoing, timely and effective communication and coordination of care. Utilizing processes and coding such as Transitional Care Management (TCM) and Chronic Care Management (CCM) will assist in the implementation of new processes and may provide additional funding to support those changes.

The Honorable Gus Bilirakis

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?**

   - **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?**

   As the law is currently written, the definition of an Alternative Payment Model for participation in the Advanced APM program is very narrow. The qualification and eligibility criteria are complicated and exclusive and, we believe, will result in most providers entering the MIPS program in 2019. In our opinion, this violates the intent of the law and we encourage Congress to strongly urge CMS to broaden the definition of qualified and eligible APMs to allow for more participation in these different payment models – specifically the medical home model – by family physicians. Furthermore, we believe CMS should address varied APMs with significant caution. Experimenting with different APMs can be a positive thing because one size does not fit all. However, there seems to be a rush among stakeholders to create narrowly focused APMs centered on specific diseases or conditions. Our concern is that a myriad of disease or condition-specific APMs will fragment care under APMs the same way that it is currently fragmented under the fee-for-service system. As this process moves forward, our vision for health delivery reform should be centered on achieving the Triple Aim of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Only APMs built on a foundation of primary care will achieve those goals.

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?**

   Patients have an important role to play in achieving the Triple Aim. The health care system can support patient engagement through value-based insurance design. Effective programs encourage patients to engage in health-seeking behavior by reducing or eliminating patient cost-sharing, encouraging preventive care, and rewarding patients for improving outcomes.

   A value-based health care system will require physicians and payers to embrace the concept of patient-centered care. This concept is the foundation of primary care, the Patient-Centered Medical Home (PCMH) model of care, and other successful delivery reforms. In fact, by acknowledging the patient as the focal point in a PCMH, with a personal physician working with a team to coordinate care, we know we can positively impact a patient's overall

health while constraining health spending. In PCMH pilots, both in the private sector as well as in Medicaid programs, it has been demonstrated that the PCMH model creates significant savings to the system. It also has been shown that paying for on-going care management is essential to enable physicians to provide the most effective patient care.

Improving access to primary care also will be an invaluable tool for patient engagement and health promotion. Research indicates that when patients have a continuous source of health care, their outcomes are better, and lower costs across-the-board. The AAFP will continue to support better tools for evaluating patient satisfaction and supporting the doctor-patient relationship. Reducing administrative burdens will certainly be invaluable in our efforts to achieving those two goals.

Improving interoperability will be an essential tool help physicians address important population health issues, promoting safety, and patient satisfaction. System interoperability, the ability to share and utilize information between two or more information systems, is critical in today's increasingly interconnected health care environment. Yet significant challenges continue to impede true information reciprocity across the spectrum of care. The AAFP understands that removing these roadblocks and eliminating isolated data silos are essential steps toward improving care quality, safety, and efficiency. That is why we support ongoing efforts aimed at creating and implementing technical standards for the secure and effective transfer of health data. We have also been engaged in the equally important task of developing process policies for how patient information is shared between providers, payers, and others. The issue of interoperability represents one of the most complex challenges facing the health care community as we pursue patient-centered health care reform. For that reason, the AAFP will continue working to bring vendors, providers, payers, and policymakers together behind a common vision of true interoperability and connected care that benefits patients and their primary care physicians. We would urge Congress to do likewise.