



# **STATEMENT**

**of the**

**American Medical Association**

**for the Record**

**U.S. House of Representatives Committee on Energy and  
Commerce  
Subcommittee on Health**

**RE: MACRA and Alternative Payment Models:  
Developing Options for Value-Based Care**

**November 8, 2017**

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**of the**  
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The American Medical Association (AMA) appreciates the opportunity to present our views to the U.S. House of Representatives Committee on Energy and Commerce concerning the Medicare Access and CHIP Reauthorization Act (MACRA) and Alternative Payment Models (APMs). The AMA believes APMs can provide significant opportunities for physicians to improve the quality and outcomes of their patients' care in ways that also lower growth in health care spending. That is why we have hosted workshops, convened meetings, and produced educational materials to support efforts by physicians in all specialties to develop APMs that will eliminate barriers to better care delivery in their practices and communities.

This year, the AMA convened two workshops on physician-focused APMs attended by hundreds of highly engaged physician leaders and medical society staff. We heard many good ideas from workshop participants who are on the cutting edge of APM design, and we want to use these concepts to help develop a more robust APM pathway under MACRA and increase physician participation in APMs.

For example, we heard from an osteopathic physician who has been participating in the Comprehensive Primary Care model in Oklahoma. The extra support available through this model allowed his practice to develop a team-based approach to care, focus on care improvements like preventing falls, provide same-day appointments for more severely ill patients, and implement patient registries that helped improve management of the practice's patients with chronic conditions like diabetes.

We also heard from a cardiologist participating in the Bundled Payments for Care Initiative in Illinois. The model has allowed his team to significantly reduce skilled nursing facility lengths of stay and hospital readmissions for heart failure patients.

Today, however, most physicians still do not have the option of participating in APMs under MACRA. Last year's final rule indicated that about five percent of clinicians would be qualified APM participants in 2017, and the forecast for 2018 is similar.

Submissions to the Physician-focused Payment Model Technical Advisory Committee (PTAC) signal that many specialty societies are developing physician-focused APMs. A number of these APMs focus on better managing chronic diseases and preventing exacerbations, improving the speed

and accuracy of diagnoses for symptoms or conditions, improving the process of selecting treatment plans, and engaging patients in helping to better manage their conditions at home. These improvements in care delivery can lead to fewer emergency visits and hospital admissions and better outcomes for patients. Several physician-focused APMs have been implemented on a small scale with support from private payers or with grants from the Centers for Medicare & Medicaid Services (CMS), while others are still being designed and have not yet been tested.

### **Examples of Physician-Focused APMs**

**COME HOME:** In New Mexico, oncologist and AMA President-elect Dr. Barbara McAneny designed a specialty medical home for patients with cancer which she called the COME HOME model. With grant funding from a CMS program, the model significantly reduced the complication rates for patients receiving chemotherapy, such as dehydration, which in turn reduced their emergency visits and hospital admissions. The model also helped reduce duplicative diagnostic testing and improve symptom management. Now Dr. McAneny's practice is participating in the Medicare Oncology Care Model, and she is also working with a private payer in New Mexico to implement an APM developed by the American Society of Clinical Oncology that builds upon the experience and lessons learned from the COME HOME model.

**SonarMD:** An Illinois gastroenterologist, Dr. Lawrence Kosinski, developed a specialty medical home model for patients with Crohn's disease and ulcerative colitis with support from Illinois Blue Cross Blue Shield. He called it Sonar because his patients were like underwater submarines and he needed a way to find out if his patients were having a problem before they surfaced in a hospital. The model grew out of data that the payer provided to him showing that, of the more than 50 percent of Crohn's disease patients hospitalized with complications of their disease, less than one third had seen any physician within the 30 days preceding their hospital admission. Interviews with the patients revealed that the symptoms of their disease had come to seem normal to them over time, so they had no way of knowing that a change needed to be made in their treatment plan to avoid a developing emergency. Under the Sonar model, participating gastroenterologists receive funding support for proactive outreach to patients by nurse care managers. Each patient receives a "ping" via text message, email or phone each month with a few structured questions. The nurses are able to use the patients' responses to these questions, called Sonar scores, to alert the gastroenterologists if they need to see the patient or adjust their medication regimen. The Sonar model has cut the rate of hospitalizations in half, and was the first APM recommended by the PTAC to the Secretary of Health and Human Services. Recently, the AMA participated in a meeting of Dr. Kosinski and CMS to discuss how to potentially implement this model for Medicare patients with an array of chronic conditions that would benefit from this type of intensive physician-nurse-patient engagement.

**Bridges to Care:** A team led by Dr. Jennifer Wiler, an emergency physician in Colorado, used grant funds to test a physician-focused APM focused on patients who utilize the emergency department multiple times per year and are insured by Medicaid. Their CMS award supported up to eight home visits within 60 days of an emergency department visit or hospital discharge by a team that provided intensive medical, behavioral health, and social care coordination services. As described in a paper published last month in *Health Affairs*, the model was able to substantially reduce the number of emergency visits by people who had been coming to the emergency department more than three times a year, and more than double their number of visits to primary care physicians.

**Value-Based Total Joint Arthroplasty (TJA):** With support from Horizon Blue Cross and Blue Shield of New Jersey, Dr. Stephen Zabinski led the design and implementation of a TJA APM that supports the provision of intensive pre-operative care focused on risks that the patient can modify before surgery, such as their weight, anemia, diabetes control, and smoking. This improvement in

the patients' preoperative functioning makes them less likely to experience postoperative complications and allows their rehabilitation to proceed more quickly and at lower cost. Within a few years, the APM achieved very significant reductions in length of stay and inpatient complication rates, more than doubled the percentage of patients discharged to their home instead of a rehabilitation or skilled nursing facility, lowered costs and achieved high rates of patient satisfaction with their care.

Patient-Centered Opioid Addiction Treatment: As a component of our efforts to help bring an end to the epidemic of opioid overdose deaths, the AMA has been working closely with the American Society of Addiction Medicine to develop a physician-focused APM for managing the treatment of opioid use disorder. As the Members of this Committee know, the opioid epidemic is widespread, growing rapidly, and has overtaken many other leading causes of death. The treatment model for opioid use disorder requires interventions that address its medical, psychological and social components, including medication-assisted treatment. The model aims to broaden coordinated delivery of the full spectrum of services needed for treatment, improve transitions to outpatient care for patients discharged from more intensive levels of care, and reduce the number of avoidable emergency department visits and hospitalizations. Payments under the model would support an evaluation, diagnosis, treatment planning, and treatment induction phase, followed by a maintenance phase. Patient-centered, comprehensive and collaborative treatment plans would cover care from induction through stabilization, treatment, and long-term recovery. It would also support more intensive management when warranted by special circumstances such as a relapse, comorbidities, or a patient choosing to discontinue the medication. Payments under the model would be adjusted based on performance on outcome measures.

Other Specialist Models: Under the Medicare physician fee schedule, physicians treating patients with chronic diseases, such as rheumatoid arthritis, asthma, headaches, and diabetes, are paid primarily based on the number of times the patient comes to the physician's office. There is no payment for many high-value services, such as phone calls to respond to patient setbacks or complications and consultation with other physicians to improve diagnosis, treatment planning, and care coordination. Payments are often inadequate to support the additional time and services needed by patients with difficult-to-diagnose or difficult-to-treat conditions. As a result, patients may be inaccurately diagnosed or inappropriately treated, experience continued symptoms of their disease or side effects of medications that could have been avoided, and be hospitalized or seen in an emergency department for problems that could have been prevented. A number of specialty societies are designing physician-focused APMs to improve diagnosis and management of chronic diseases, including the American Academy of Neurology, American College of Rheumatology, American College of Allergy, Asthma & Immunology, American Association of Clinical Endocrinologists and others. Several of these models include elements in common, such as: a one-time payment to support a comprehensive diagnostic work-up, testing, and development of an initial treatment plan; monthly payments to cover the treatment and care management needed to get the condition under good control; payments to cover ongoing care, either by a primary care physician for patients whose conditions are well-controlled or continued care by a specialty team for patients with more difficult-to-control conditions or complex comorbidities; and support for collaboration between specialists and primary care physicians during diagnosis and treatment planning and when needed due to disease progression or other issues.

### **PTAC Technical Assistance**

The PTAC reports to the HHS Secretary of May 31, 2017 on Project Sonar and on the COPD and Asthma Monitoring Project included the statement, "Because PTAC has been advised that it may not provide technical assistance, the Committee is hopeful that the Secretary would consider options for

providing technical assistance to this and other submitters.” The AMA urges Congress to clarify the MACRA statute to ensure that the PTAC can provide data and technical assistance to individuals and organizations developing APM proposals.

One of the greatest barriers physicians face in designing and implementing new approaches to care delivery and payment that will reduce Medicare spending is their inability to obtain data on the full range of services their patients are receiving today. Most of the savings from improved care delivery come from lower spending on services such as hospital admissions and post-acute care that are not delivered directly by physicians, and some of the biggest opportunities for improved care coordination come from avoiding duplication and conflicts with services delivered by other providers. Physicians do not have access to information about the other services their patients are receiving that would enable them to identify and quantify opportunities for savings or take action to achieve these savings. If the PTAC could provide these types of data to those developing APM proposals, we believe it would significantly enhance the quality of the submitted proposals and greatly increase the likelihood of their testing and implementation.

APM developers also need assistance with technical issues such as risk stratification. The risk adjustment methodologies used in the Medicare and Medicaid programs to date are designed to address differences in patient needs among large populations associated with a health plan or hospital. These methods cannot be appropriately transferred for use in risk stratifying patients associated with a medical practice or those with a particular condition. Current risk adjustment methods, for example, do not take into account patients’ stage of disease, functional status, and whether they have a caregiver at home. Factors like these can have a significant effect on treatment plans, adherence, and patient outcomes. The PTAC report to HHS on “The COPD and Asthma Monitoring Project” describes questions about the project’s proposed risk adjustment methodology and indicates that the proposal would benefit from technical assistance on this and other issues, but notes that “PTAC has been advised that it may not provide technical assistance.”

### **Policy Recommendations**

Recently the AMA applauded an announcement by the CMS Administrator regarding a new direction for the Center for Medicaid and Medicare Innovation. We were extremely pleased that this announcement sought comments on how CMS can help develop APMs for specialists, engage in limited scale model tests, adopt behavioral health APMs, test models involving direct contracting with patients, and expand opportunities for participation in Advanced APMs under MACRA. The AMA will be making a number of recommendations to CMS in response to this Request for Information.

The AMA is also extremely pleased that Medicare has finalized coverage of remote patient monitoring in the fee-for-service program subject to a number of coverage requirements. This is an important bridge for physicians being paid through the Medicare fee schedule to transition into APMs as remote patient monitoring provides new tools that will help patients and physicians actively manage chronic conditions and improve population health.

Several of the key challenges facing APM participants and developers are highlighted below, along with our policy recommendations to address them.

**Need for a True Innovation Lab:** The internal CMS process for developing each model that it wants to test takes 18-24 months. Although Congress established the PTAC to review APMs proposed by stakeholders, there is no real pathway for these stakeholder-developed APMs to be tested and implemented. The AMA recommends that CMS encourage physicians to develop an array of

approaches that make sense for the patients they treat in the specific environment where they practice. CMS should then be ready to quickly test multiple approaches to see which ones work, instead of trying to decide on one single best approach before any testing is done. In addition, the process needs to be speeded up. We are about to enter the second MACRA performance period with only about five percent of clinicians in Advanced APMs. Other industries have methods for rapid prototyping and CMS should develop a similar approach to testing APMs. CMS and the PTAC also should better integrate their processes.

Do Not Tie Financial Risk to Total Spending: Physicians participating in an APM can appropriately take accountability, including financial risk, for aspects of their patients' care that they can control or influence. These include decisions on the appropriateness of tests they order, procedures they perform, medications they administer, whether patients are discharged to their homes or to expensive facilities. Physicians should not be expected to take risk for the prices of drugs and biologics or the severity of their patients' conditions and their functional status. Most Medicare spending does not go to physician services, so increasing physicians' financial risk for Medicare spending on hospitals and drugs will be a major barrier to increasing their participation in APMs.

Lessen Administrative Burdens: Many of the concerns that we hear from physicians about the current payment system have more to do with administrative and regulatory burdens than with payment rates. Prior authorization, certification, documentation and reporting requirements, and electronic health record systems that do more to hinder than support patient care are enormously burdensome. In developing APMs, CMS should take maximum advantage of opportunities to lessen these burdens by waiving Medicare and other payer requirements. This could allow for new pilot programs using telehealth, for example. In addition, when APMs require any type of reporting or documentation, payment rates should be adequate to cover physician costs associated with these tasks.

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The AMA strongly supports efforts to reduce barriers to higher quality care and lower costs in current payment systems through the development of APMs. We appreciate the opportunity to provide our comments on this matter and look forward to working with Congress and CMS on developing options for value-based care.