AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Joseph R. Pitts
Chairman
Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pitts:

On behalf of the physician and medical student members of the American Medical Association (AMA), I want to thank you again for the opportunity to provide our views on the Medicare Access and CHIP Reauthorization Act (MACRA). We commend you and the Members of the Subcommittee on Health for addressing important implementation issues to ensure that physicians are prepared for the new Medicare payment reforms.

Attached to this letter are our responses to your supplemental questions from the April 19, 2016 hearing entitled "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms." If you have any further questions or need additional information, please contact Aiken Hackett, at aiken.hackett@ama-assn.org or (202) 789-7475. We look forward to working with you and the Subcommittee to ensure that MACRA implementation is a success for patients and physicians.

Sincerely,

Barbara L. McAneny, MD

Attachment
cc: James L. Madara, MD

Responses of the AMA to Supplemental Questions from the House Committee on Energy and Commerce, Subcommittee on Health

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?**

   As a practicing physician, I felt the burden of the broken SGR payment system for many years. With half of my patients covered by Medicare, the threat of significant payment cuts was very real and jeopardized the viability of our practice every year. I could not justify hiring people to develop alternative care models or improve patient care when I would have to lay them off if the Medicare payment reductions went through. This constant threat of cuts discouraged many physicians from dedicating resources towards innovation or devoting time to developing new care models.

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

   Effective communication methods vary since physician practices differ in their resources and level of understanding of new requirements. Accordingly, physicians need both basic information and more detailed tools to prepare for significant changes. The AMA has tried to provide both of these types of materials to assist in understanding MACRA. We have created plain language interpretations of the law and have also formed taskforces of medical state and specialty societies to drill down and discuss specific details of MACRA.

   Physicians also need the requirements to be placed into context of their practices. To do this, the AMA has an extensive practice transformation platform, known as Steps Forward, which offers Continuing Medical Education (CME) training modules for physicians and their practice administrators on many issues related to MACRA, including implementation of electronic health records (EHRs) and improving team-based care. We also are developing a free payment model evaluator for physicians and practice managers to assess practice readiness, and provide implementation resources for the Merit Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). We hope that CMS will not create too high of a bar for APMs but will encourage and allow innovative models to count under MACRA.

   Finally, physicians and their representatives need a direct line of communication with the agency and officials who are implementing the changes. Oftentimes, unique questions arise that require guidance from those who are implementing the law. To date, the Centers for Medicare & Medicaid Services (CMS) has worked with the AMA to listen to our concerns and work towards a successful implementation of MACRA. We, however, want to continue to push the agency for clear answers and enhanced access to data to succeed under the new law.

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?**

   The AMA strongly agrees that MIPS offers significant improvements over the current system due to the flexibility provided in the law. By creating a single performance reporting program, MACRA

creates an opportunity to reset and improve quality measurement as well as the other reporting requirements. Specifically, MIPS has the ability to streamline measures, reduce reporting burden, create flexibility to report on clinically relevant measures, encourage participation, and overall improve care. Given this opportunity to improve current reporting programs, the medical community would have serious objections to any proposal that merely moves the current incentive programs into MIPS. The goal of MIPS should be to create a new program with a limited set of requirements but with more options for meeting those requirements. Success should be counted in terms of how many physicians have an opportunity to participate in and be judged on initiatives that really matter.

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?**

   The AMA strongly agrees that access to information and feedback is necessary to be successful in MACRA. Current feedback reports provided by CMS are out of date and lack key details to understanding the methodologies used to arrive at the benchmarks and other calculations made. This creates frustration and distrust, and must be avoided going forward.

   To improve feedback reports, CMS should include the ability to see high-level, overall performance information, as well as drill down tables with individual patient information. Where appropriate, CMS should aim to display feedback and performance measurement information in graphic form with additional details displayed elsewhere to improve comprehension. CMS must also be forthcoming in regard to the methodologies used to comprise any benchmarks or attribute patients for a particular measure. This information must be clearly identified and easy to interpret. Where there is a dispute about the accuracy of the data, CMS should ensure an open line of communication with the practice or physician to reconcile any potential errors.

   Lastly, CMS should consult stakeholder groups continuously to determine the best presentation and most meaningful format for sharing ongoing, actionable performance feedback information with physicians and practices. As technology is constantly changing, it will be critical for CMS to take an ongoing approach to improving the way performance information is disseminated to physicians and practices. Stakeholders must be included in this process so that feedback can be provided in a format that works best for physicians and is meaningful to their practice's ongoing improvement activities.

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?**

   Telehealth and health information technology (health IT) will be essential tools for both MIPS and APMs. The integration of telehealth technologies into existing clinician health IT systems will be essential to reap the benefits of reducing access barriers to medical care. The integration of telehealth and health IT tools can maximize the benefit of healthcare resources and provide flexible opportunities for patients to engage with clinicians and better self-manage their care. They can also increase access to medical care not only for geographically remote and traditionally underserved populations but remove barriers that many patients face while also improving affordability. Efforts to

improve care coordination will depend on these tools to be able to transmit and incorporate data and provide new lines of communication across care settings.

One of the biggest barriers to greater adoption of telehealth is the lack of Medicare payment. APMs are no longer restrained by the antiquated Medicare geographic, originating site, and technology restrictions on coverage. In addition, it is expected that new technologies that support or enable telehealth options will only continue to grow. APMs offer an opportunity to provide telehealth services with demonstrated clinical benefit to more Medicare beneficiaries, which will drive further innovation.

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?**

Both clinical data registries and EHRs can facilitate data reporting and improve feedback to physicians. Specialty societies have improved the relevance of quality reporting by developing measures that are more clinically appropriate for specific physicians. Registries also provide more actionable and timely information back to physicians on their performance and, in some instances, include data from multiple payers, which can offer a more comprehensive picture of the care provided. EHRs, when implemented appropriately, can also improve reporting by automating the process for collecting and sending data.

Allowing reporting through both options can help decrease administrative burden. Physicians, however, should be allowed to pick the most appropriate reporting option. For example, a physician may be able to identify clinically relevant electronically specified (e-specified) measures that can be reported through an EHR but also might identify a few other relevant measures that are not yet e-specified and can only be reported through a registry.

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?**

Certain measures today are irrelevant for many physicians—either because no patients get attributed to them or because they had little to no opportunity to influence the costs that are attributed to them. Shortcomings in the attribution and risk adjustment methodology exacerbate the problem and limit the appropriateness of these measures to evaluate care quality. Current methodologies also do not adequately protect against cases where one very bad patient outcome can inappropriately skew the data. For example, where, in one month, there are a small number of patients who just happen to be diagnosed with the same serious condition and this drastically changes the data for that period.

More appropriate risk adjustment will help improve the relevance and accuracy of the MIPS program. If properly selected and designed, measures tied to episodes of care could increase the reliability and applicability of resource use measures and make physician feedback reports more actionable. In addition, adjustments to the methodology should take into account the time needed to change patient behavior and should not include activities that are outside of the physician's control. This would also offer an opportunity to adapt risk adjustment and attribution methodologies to the individual

condition or service being measured. Overall, this would create a MIPS program that is more accurate and relevant to improving care.

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?**

     The AMA views the establishment of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and the development of physician-focused APMs as critical components of MACRA. We see physician-focused models as an opportunity for major transformation in the delivery of care for patients with serious conditions. For example, a diabetes APM that reduces complications and hospitalizations, improves patient self-management, and slows disease progression, would be a major advance for Medicare patients. Likewise, new models for managing cancer patients' care can improve outcomes through more accurate diagnosis and staging and better treatment planning. Allowing physicians to experiment with these different models will encourage innovation in treatments while address some of the most challenging diseases and problems in health care. We are urging CMS to allow these physician models to qualify as APMs under MACRA. Two-sided financial risk should not be required in all models since this may limit the ability for 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?**

     My own experience with APMs has shown that when physicians have the opportunity to innovate, these models can be successful. In 2012, I received a Center for Medicare and Medicaid Innovation (CMMI) grant to replicate across the country, how my practice was providing cancer patients with better care at a lower cost. By implementing a medical home, we were able to cut hospitalizations in half and create a model for chronic care management that could be replicated by other practices.

     To lay a positive foundation, CMS should provide physicians with access to data, in an easily understandable format, to help them develop appropriate and successful models. Physicians do not know what other services their patients receive from hospitals, labs, and other physicians and providers—making it impossible to complete APM proposals without this information. In addition, CMS should establish a clear pathway for physician-focused payment models, particularly those that are proposed to the PTAC to be implemented by CMS as qualified APMs.

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 play a key role in ensuring the success of MACRA. The AMA believes MACRA can create a new system that is more patient-centric and encourages patient engagement in their care decisions. MACRA provides patients with key opportunities through better data sharing, innovative care models, and improved health IT. In particular, the AMA believes patients should work with physicians to improve quality reporting by creating patient experience and care coordination measures. Including patient engagement as part of the quality development and reporting process ensures that providers put patient needs first.