



Statement for the Record

American College of Physicians

Hearing before the Energy and Commerce Health Subcommittee

On

Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for

Medicare Payment Reforms

April 19, 2016

My name is Robert McLean. I represent the American College of Physicians (ACP), the nation's largest medical specialty organization, representing 143,000 internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults, internal medicine subspecialists, and medical students who are considering a career in internal medicine. I am a member of ACP's Board of Regents and Chair of its Medical Practice and Quality Committee. I am a practicing physician in New Haven, CT who sees over 80 patients per week, am board certified in internal medicine and rheumatology, and am an Associate Clinical Professor of Medicine at the Yale School of Medicine. I am part of a multi-specialty group that, in recent years, aligned with a larger network, now called the Northeast Medical Group of the Yale New Haven Health System. Today, I am pleased to share with you the College's perspective on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), a law that not only repealed the flawed Medicare Sustainable Growth Rate (SGR), but one that of equal importance, creates pathways for physicians to transition to payment and delivery systems aligned with the value of care that we provide to our patients.

On behalf of the College, I want to express our appreciation to Chairman Pitts and Ranking Member Green for convening this hearing and for your shared commitment in wanting to ensure that the payment and delivery system reforms created under MACRA are implemented successfully and as

intended by Congress. We also appreciate the Committee inviting input from the physician community during the implementation process.

Enactment of MACRA represented the rare situation where physicians, nurses, patient and consumer advocacy groups, and so many others, were able to come together with members of both political parties, in both chambers of Congress, to help craft legislation to create a better physician payment system, one that:

- Creates opportunities for physicians to better serve our patients by providing high value, coordinated, and patient-centered care, through innovative Alternative Payment Models (APMs) like Patient-Centered (sometimes called Primary Care) Medical Homes (PCMHs), supported by a better payment system unique to each APM, or through creating incentives within the existing Medicare fee-for-service (FFS) system aligned with value, called the Merit-Based Incentive Payment System (MIPS)
- Streamlines and harmonizes existing quality reporting programs as they migrate into MIPS, which we hope will reduce the current unnecessary regulatory burdens of complying with 3 different quality reporting programs, each with their own measures, deadlines, rewards and penalties.
- Repealed the flawed SGR formula, ridding physicians and their patients from the constant threat of across-the-board payment cuts unrelated to their quality or value.

We sometimes forget, even though it has only been a year, just how important it was to repeal the SGR and replace it with MACRA.

ACP has been a strong supporter of MACRA and embraces its shift from a volume-based payment and delivery system, as was the case under the preceding fee-for-service system with yearly adjustments based on the SGR formula, to one of value, accountability, and patient-centered care. ACP has been active in providing feedback on our MACRA implementation priorities to the Centers for Medicare and Medicaid Services (CMS) in anticipation of the release of the proposed rule and aggressively involved in

educating and providing support to its members about the reforms to come under MACRA. It is on these two areas that I would like to focus my testimony.

OVERVIEW OF ACP VIEWS ON MACRA

Repeal of the SGR has been a priority of ACP's, and nearly all of medicine, for more than a decade. As outlined above, thanks to the passage of MACRA, physicians and their patients no longer will have to be concerned with impending yearly payment cuts as a result of the flawed SGR formula and no longer will this burden of uncertainty be hanging over physician practices. Equally important, the law provides strong incentives for physicians to engage in activities to improve quality; streamlines existing quality reporting programs; and provides additional support to physicians who participate in PCMHs, and other APMs, shown to improve outcomes and the effectiveness of care provided.

More specifically, MACRA offers physicians and other clinicians the opportunity to essentially set their own conversion factor for the determination of their Medicare Part B payments. These payments are determined by relative value units, multiplied by a dollar conversion factor. Although the conversion factor was supposed to keep pace with inflation, the SGR resulted in every physician's conversion factor being cut by the same scheduled amount, no matter how cost-effective they were or the quality they provided to patients. MACRA fundamentally changes this, because the annual adjustment in each physician's conversion factor, starting in 2019, will be based on each physician's contributions to improving quality and providing care more effectively: if physicians are able to contribute to improved quality or lowered costs without reducing quality, they will get a higher annual conversion factor adjustment; if they are unable to contribute to better quality and lower costs, they will have a lower annual conversion factor adjustment. This gives physicians far more control over their annual payments, essentially individualizing the conversion factor adjustments each year, rather than the SGR imposing across-the-board cuts on everyone. Or, alternatively, physicians can participate in an APM aligned with value and quality.

It is also important to consider MACRA in the broader payment and delivery system environment, where there is a recognized need and activity by numerous stakeholders (such as other public and

private payers, employers, and consumers) to move toward payment for value rather than the volume of services. Approximately one year ago, the Department of Health and Human Services (HHS) launched the Learning and Action Network (LAN) to bring together partners in the private, public, and non-profit sectors to transform the nation's health system to emphasize value over volume. This effort has actively involved multiple stakeholders to collaborate and develop innovative ideas, recommendations, and resources to help facilitate system-level transformation, with a mission of helping HHS meet and even exceed the goals the Department has set with regard to linking the payment for more and more clinicians and practices to quality and value.

The significant challenges before all of us now are to provide education and support to physicians as MACRA is rolled out, within this evolving health care delivery-system environment, in order to facilitate their success and to ensure that the law is implemented by CMS in line with Congress' intent to truly improve care for Medicare beneficiaries and move toward a meaningful value-based payment and delivery system. Along these lines, ACP is extremely appreciative of the Subcommittee on Health holding this hearing to discuss our efforts, and those of other physician societies, and we are interested in continuing to work with the Subcommittee to ensure the successful implementation of MACRA.

For years, many looking to improve dysfunctional aspects of our health care system have referred to the laudatory goals of the "Triple Aim:" improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. However, when I would mention this to my colleagues in practice, I frequently received frustrated and glazed looks. I am told those are nice big ideas, but "Are you kidding?" And then I am given a list of real-world concerns, such as: "I am struggling with my electronic health record, I am overwhelmed with these regulations, I am unable to deliver care to my patients efficiently with all the prescription and test prior-authorizations; I am given data on clinical metrics and do not know what to do with it; my patients are unhappy because I am taking visit time away from them to deal with all of these hassles; and finally I have to worry every year that my Medicare fees will be cut up to 20 percent or more because of some crazy formula."

In that environment, can anyone wonder why there is such concern about physician burnout? Yet we must recognize that we cannot achieve the Triple Aim if our physicians and other clinicians are suffering from burnout. Hence the Triple Aim is now becoming the “Quadruple Aim” with a fourth goal of “improving the work life of health care clinicians and their staff.”

When I explain to my colleagues that the MACRA law will align and simplify some of the measures and reporting; will truly reward those who have made investments or evolved into advanced practice structures like PCMHs or other alternative delivery models where data and clinical metrics are used to improve population health and health care delivery; and will eliminate the yearly financial anxiety created by the dreaded SGR—then those glazed and frustrated looks change dramatically. With surprise, I am then asked, “You mean this law really does things that will simplify our lives in practice and allow us to focus more on delivering high quality care to our patients with no more yearly panic over across-the-board SGR-mandated fee cut threats?” And I tell them, “Yes.”

I truly believe that if MACRA can get rolled out with its best intentions implemented well, it is a remarkable “shot in the arm” Congress can give to physicians and the rest of the clinician community to combat burnout, and thereby enable our system to realistically strive for the Quadruple Aim.

ACP’S IMPLEMENTATION PRIORITIES

At this stage in the process, ACP is encouraged that CMS has been open to hearing from us and other stakeholders on how best to implement MACRA so that it allows our members the flexibility and resources they need to be successful with value-based payments, as Congress intended. However, because most of the rulemaking has not yet been issued, it is impossible to assess with any certainty where precisely the agency is in ensuring that implementation proceeds as needed.

The following priorities are the ones that we believe are most important for CMS to address:

1. **Creating a Learning System.** We believe that CMS must use the opportunity provided through the new MACRA law to build a learning health and healthcare system. It is critically important that the new payment systems that are designed through the implementation of MACRA reflect

the learnings from the current and past programs and also effectively allow for ongoing innovation and learning. The College recognizes that taking an approach such as this will require flexibility in design that will be extremely challenging to implement, particularly for a program that must be guided by federal regulations. In our communications with CMS, the College has noted critical areas that should be built with considerable flexibility and an aim of understanding how to best refine the regulations over time based on the data and evidence that emerge, lessons learned, and best practices.

2. **Ensuring Patient-Centeredness.** ACP recommends that CMS work to ensure that patients, families, and the relationship of patients and families with their physicians are at the forefront of the Agency’s thinking in the development of both the MIPS and APM pathways, including the development and implementation of the performance measures to be used within these programs. It is critically important to recognize that the legislative intent of MACRA is to truly improve care for Medicare beneficiaries and thus, the policy that is developed to guide these new value-based payment programs must be thoughtfully considered in that context.
3. **Establishing Better Measures and Less Burdensome Reporting.** The College strongly recommends that CMS actively work to improve the measures to be used in the quality performance category of MIPS, as Congress clearly intended as it harmonized the existing Physician Quality Reporting System (PQRS), Medicare Value-Modifier, and Meaningful Use of Electronic Health Records (EHRs) into the MIPS program, while adding a new category of practice improvement measures and reporting. We have provided CMS with detailed recommendations on quality measurement and reporting to CMS in our comments on its quality measurement plan, and in its request for information. Our recommendations included the following:
 - In the short term, ACP encourages CMS to consider adopting a core set of measures that are methodologically sound and Measure Applications Partnership (MAP)-endorsed for use in the MIPS and APM programs. CMS should consider utilizing the core set of measures identified through the America’s Health Insurance Plans (AHIP) coalition pending approval by the organizations involved, which includes both physician and consumer organizations and CMS.

- Over the longer term, it will be critically important for CMS to continue to improve the measures and reporting systems to be used in MIPS to ensure that they measure the right things, move toward clinical outcomes and patient experience, and do not create unintended adverse consequences.
 - ACP is strongly supportive of filling the critical gaps in quality measurement; obtaining stakeholder input into the measure development process; and focusing on outcomes-based measures, patient and family experience measures, care coordination measures, and measures of population health and prevention.
 - ACP also strongly recommends electronic specification of the measures as one of the top considerations for filling measure gaps.
 - It is critically important that the data collection and reporting burden related to the quality category (as with all of the MIPS categories) be minimized.
 - ACP recommends that CMS work to ensure that performance measurement and reporting becomes increasingly patient-focused.
4. **Creating Realistic Pathways for Patient-Centered Medical Homes.** The College is very pleased that MACRA supports PCMHs, through both the MIPS program and as an APM. Under MIPS, “certified” PCMHs, including both primary care and specialty 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 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. The College has urged CMS to create multiple ways for PCMHs to obtain certification. The College also supports the inclusion of Medicaid-recognized medical homes as eligible APM entities based on their comparability to medical homes expanded under the Center for Medicare and Medicaid Innovation (CMMI) authority.

Comprehensive Primary Care Plus Initiative:

CMS’s announcement this week of the new *Comprehensive Primary Care Plus* Initiative is particularly important to note, because it potentially will create a pathway for thousands of

more physician practices to incorporate the PCMH model into their practices, which would then make it likely that they would qualify as an APM, or receive higher MIPS scores for practice improvement, as authorized by MACRA. CMS envisions that the program will be available “in up to 20 regions and can accommodate up to 5,000 practices, which would encompass more than 20,000 doctors and clinicians and the 25 million people they serve” —a 10-fold increase in the number of participating practices, and a nearly three-fold increase in the number of regions where the program will be offered.¹

The *Comprehensive Primary Care Plus* (CPC+) program is modeled on the *Comprehensive Primary Care Initiative* (CPCi), a 4-year pilot of advanced PCMHs that has been rolled out in 500 practices in 7 regions around the country. CPCi is scheduled to wrap up in October of this year; its participating practices will have an opportunity to transition into the new *Comprehensive Primary Care Plus* program, and many more practices will be invited and eligible to join. The College believes that the *Comprehensive Primary Care Plus* program has the potential of offering greater support for practice transformation as well as greater flexibility.

- **Flexibility:** Physicians and their practices can choose from two different participation tracks, with different care delivery requirements and payment methodologies that reflect how advanced they are in incorporating PCMH principles into their care delivery. Track 1 is for those that are less advanced in fully implementing the attributes of advanced PCMHs; track 2 is for more advanced practices.
- **Support for Practice Transformation.** CPC+ can potentially provide practices with more financial support for practice transformation especially when compared to traditional FFS Medicare, because it gives them more Medicare dollars upfront, which will be *in addition* to the amounts they get reimbursed for individual patient encounter (evaluation and management service) codes.

¹ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-04-11.html>

- Track 1 practices will receive an average risk-adjusted payment of \$15 per beneficiary per month (PBPM); they can earn another \$2.50 PBPM if they do well on metrics of quality and utilization. For track 1 practices, these upfront PBPM payments would be *in addition* to getting 100% of their usual Medicare FFS payments for office visits and procedures billed a la carte.
- Track 2 practices would receive an average risk-adjusted PBPM payment of \$28 (and up to \$100 PBPM for the highest risk patients); they can earn an additional \$4 PBPM based on performance. However, CPC+ also adds financial risk to the equation. If track 1 practices do not meet their performance metrics, they will have to repay Medicare for the \$2.50 PBPM incentive payment. If track 2 practices don't meet their metrics, they would repay Medicare for the \$4.00 PBPM incentive payment. For track 2 practices only, their upfront PBPM payments will be offset by reduced payments for separately-billed office visits and other evaluation and management services. In an editorial published in the Journal of the American Medical Association, CMS officials [explain](#) how this will work:

“Track 2 practices will receive an up-front payment of a portion of their expected evaluation and management claims on a per capita basis, independent of claims. Subsequent claims for evaluation and management services will be paid at a commensurately reduced rate. As the ratio of the hybrid payment is titrated up during the model, the reduced payment for billed evaluation and management services will pay practices for the marginal cost of an office visit, making practices ‘incentive neutral’ to the mode of care delivery and allowing them the flexibility to deliver care in the manner that best meets patients’ needs—without being tethered to the 20-minute office visit. Practices might offer non–face-to-face visits (e.g., electronic or telephone), offer visits in alternate locations, or simply provide longer office visits for patients with complex needs. CMS will monitor practices to ensure delivery of quality health care.” Non-evaluation and management services for track 2 practices would continue to be paid 100% of the usual rates.

For physicians and their practices considering track 2, the decision likely will be based on whether the additional upfront risk-adjusted PBPM payments, and the flexibility such advance payment provides them, outweighs the loss of revenue that will result when evaluation and management services billed downstream are paid at a lower rate.

The Comprehensive Primary Care Plus program may also give practice access to extra support and revenue from payers other than Medicare: CMS will be seeking formal commitments from non-Medicare payers to support participating practices, and will only launch the program in localities where there is such a commitment from enough payers.

While the College is strongly supportive of the Comprehensive Primary Care Initiative as a pathway for physicians and their practices to transition to PCMHs as recognized by MACRA under both the MIPS and APM pathways, we believe that its success will ultimately depend on Medicare and other payers providing physicians and their practices with the *sustained* financial support needed for them to meet the goal of providing comprehensive, high value, accessible, and patient-centered care, with *realistic* and *achievable* ways to assess each practices' impact on patient care. The College is committed to working with CMS on the details of implementation to ensure that the program is truly able to meet such requirements of success.

- 5. Defining Eligible APM Requirements.** The College recommends that CMS employ a very broad definition of entities that should be considered eligible APM entities as a means to promote innovation and recognize the heterogeneity of services and clinicians covered under Medicare. ACP recommends that selection of quality measures for an APM should be based on the goals and design of the specific APM and harmonized with those measures being used within the MIPS program—as well as across the multiple payers that are anticipated would be involved with APMs. The College strongly recommends that certified EHR technology (CEHRT) requirements for APMs be viewed as separate from requirements included under the Meaningful Use EHR Incentive Program. Additionally, we believe that CMS should expand its

definition of nominal financial risk to include recognition of non-billable costs that are currently overlooked (e.g., start-up and maintenance costs, and lost revenue to a system resulting from efforts to reduce unnecessary utilizations).

6. **Creating Pathways for Other Physician-Focused APMs.** The process for approval of Physician-Focused Payment Models (PFPMs) must be clearly defined and implemented to be consistent with the Congressional intent that this approach be a pathway to encourage the development and approval of multiple valued-based payment models. There needs to be a clear understanding that models that are judged by the Physician-focused Payment Model Technical Advisory Committee (PTAC) to meet the established criteria will be tested on a fast-track basis through CMMI and, if determined to be successful, expanded and implemented as part of the APM track in line with the Agency’s authority. The College supports the concept of CMS using the PFPM pathway primarily (but not exclusively) to qualify payment models for physician and other healthcare professional specialties who are not eligible to broadly participate in current APMs or models already under review or testing through CMMI. CMS should work collaboratively with medical societies and other organizations developing proposals to provide feedback on drafts and provide data up-front to help in modeling impacts. Furthermore, ACP encourages CMS to assist stakeholders through these processes in developing proposals that would qualify for the APM “bonus” payment contained in the statute. The College is particularly interested in the priority testing of the PCMH specialty practice model.
7. **Providing Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas.** ACP recommends that CMS give consideration to the complexity of transforming to a value-based payment model and provide technical assistance to address identified needs specific to the practice setting. The College strongly recommends that CMS collaborate with the many specialty organizations—at the national, regional, and local levels—to use their established communication channels to provide a consistent message to their membership. MACRA specifically includes \$20 million annually for five years for technical assistance to small and rural practices to help them develop the capabilities they will need to successfully participate in the new payment systems established under the law—and CMS has

recently posted a solicitation to begin funding this technical assistance. The College plans to engage with CMS and others to ensure that the most appropriate entities receive this funding.

ACP EDUCATIONAL AND SUPPORT EFFORTS FOR MACRA

Educational and Support Goals

Recognizing the pressing need to make ACP members, as well as other physicians and clinicians, aware of and ready for the Medicare Part B payment changes that they will be facing as MACRA is rolled out, the College initially identified a set of goals around which to focus our efforts and to measure success over time. These goals include the need to help physicians:

- Understand the significant and complex changes in approach to Medicare Part B payments coming their way, the rapid timing of those changes, and why this is an improvement over the previously uncertain payment updates and disparate quality reporting programs.
- Realize the importance of these changes not only to them and their practices, but also to their patients, and the health care system overall—so it is important to get engaged now in order to ensure a successful implementation of MACRA.
- Identify what they and their staff can do now and over the longer term to understand MACRA, make informed decisions, and be successful—including consideration of the PCMH and PCMH Specialty Practice principles.
- Learn—and engage in improving—what ACP has to offer and is developing to help them be successful in the new Medicare Part B payment systems and beyond.

Educational Approaches

As is discussed earlier, MACRA is a critically important law intended to improve the Medicare Part B payment environment for physicians; however, the complex and extensive changes that this law requires will be challenging for physicians to understand and make the needed adjustments for, particularly since physicians also must continue to address their patients' and patient families' daily needs, as well as ensure that their practice business needs and obligations are met. Therefore, the

College has identified physician education on MACRA as a top priority—first outlining the goals listed above, and now putting them into action in a variety of ways.

One of the most direct approaches to education for our members is through in-person meetings. ACP’s Internal Medicine Meeting 2016 is taking place here in Washington, D.C. on May 5th to 7th. This meeting, which is held annually, brings together over 6000 internal medicine physicians from across the country to attend more than 200 scientific sessions. During the 2016 meeting, the College will be providing 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 expect to be able to 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 multimedia displays.

ACP also provides and supports several publications for our members and beyond. The *Annals of Internal Medicine* is our flagship scientific publication and forms one of the most widely cited peer-reviewed medical journals in the world. The journal has been published for 80 years and accepts only 7 percent of the original research studies submitted for publication. ACP members and staff have been given the opportunity to publish a series of articles over the past several years to address “health policy basics” on a number of current payment and delivery system issues, including PQRS, the CMS Open Payments Program, Medicaid expansion, insurance marketplaces, and ICD-10.² This series is expected to continue and will now focus largely on MACRA implementation issues. Additionally, the College is planning to include advertisements in *Annals*, both print and online, to inform readers about our educational and practice support resources.

² http://annals.org/solr/searchresults.aspx?q=health%20policy%20basics&fd_JournalID=90&SearchSourceType=3

The College also offers our members the *ACP Internist*³, a monthly print and online publication that provides news and information for internists about the practice of medicine and reports on the policies, products, and activities of ACP, as well as *ACP Internist Weekly*⁴, which provides updates every Tuesday to our members on critical topics. ACP has been actively outreaching to our members via the *Internist* through a series of articles focused on MACRA and its components of MIPS and APMs.⁵ Additionally, the College provides our members with the *ACP Advocate*⁶, a bi-weekly, e-newsletter created to provide ACP members with news about public policy issues affecting internal medicine and patient care. This publication has also included a series of educational articles on MACRA.⁷ Related to the *ACP Advocate* newsletter is a regularly published ACP Advocacy blog by Bob Doherty, ACP's Senior Vice President for Governmental Affairs and Public Policy.⁸ This blog has and will continue to include a number of posts focused on helping our members better understand MACRA, how it will impact them, and actions that they should take to prepare and succeed. Finally, another publication that reaches our national membership audience is the *Annual Report from the Executive Vice President (EVP)*, where the College's EVP provides a review of the past year's accomplishments, programs, initiatives and collaborations. This report, typically released in July of each year, will also include educational content related to MACRA. At a more regional and local level, ACP's chapters also produce newsletter publications for their members on a regular basis. These newsletters are another way that education and information on practice support resources will be provided.

Beyond in-person meetings and publications, a critical touchpoint for our membership and beyond is via our website, where we have created a section entirely dedicated to MACRA education.⁹ This website includes links to all of the educational resources discussed above, as well as practice support resources, and will continue to grow as the MACRA rulemaking gets underway. The website also

³ <http://www.acpinternist.org/>

⁴ <http://www.acpinternist.org/weekly/>

⁵ [Positioning Your Practice for Alternative Payment Models](#) (ACP Internist, Feb. 2016); [Positioning Your Practice for a New Payment System](#) (ACP Internist, Jan. 2016).

⁶ <https://www.acponline.org/advocacy/acp-advocate>

⁷ [ACP's Recommendations to Congress about Implementing the New Payment System](#) (The ACP Advocate, Dec. 4, 2015); [What You Should Know About Alternative Payment Models](#) (ACP Advocate, June 12, 2015); [What to Expect in the Post-SGR Era](#) (ACP Advocate, May 8, 2015).

⁸ <http://advocacyblog.acponline.org/>

⁹ <https://www.acponline.org/macra>

allows the College the opportunity to implement a number of innovative multi-media and interactive approaches to education in order to better meet the needs, learning styles, and availability of our members. These approaches either currently or are expected to include frequently asked questions, formal recorded briefings of varying lengths, voice-over PowerPoint presentations, slides with descriptive notes, short videos and audio recordings focused on specific components of the law (and the forthcoming regulations), animated and interactive brochure(s) to help explain implementation details and provide concrete advice, and more. Additionally, the College is developing a new section of the website focused more broadly on practice transformation to ready physician practices for success within MACRA and beyond, given that the health care environment as a whole is moving toward value-based payment- and delivery-system approaches. Both the MACRA and Practice Transformation sections of our website also will allow us to regularly collect and share stories, best practices, and advice from physicians currently engaged in these efforts with their colleagues—as physician-to-physician information is known to be an effective driver of learning and change. Finally, for those that are seeking even further information and advice, the College will be providing a helpline email address so that our members can contact us as needed.

Support Approaches

Taking the education described above to the next level—and provide physicians with practical advice, tools, and resources—is critical to the successful implementation of the law and to ensuring that physicians are able to thrive as it is rolled out. Therefore, the College is actively working to implement short, medium, and longer term assistance opportunities for our members.

MACRA Top Ten Actions for Today:

In the most immediate term, as physicians are learning about the law and as all stakeholders are awaiting the initial rulemaking, many doctors and their staff are wondering what they can and should do now to help ensure success. Given the significant number of unknowns regarding MACRA implementation, this can be a difficult question to answer; however, when one considers the overall intent of the law to improve care and move toward true value-based payment, it becomes more clear that physicians and practices should make every effort to move toward engaging in quality

improvement and practice transformation efforts—as that will be a huge benefit to them no matter how the MACRA rules are ultimately constructed. Along these lines, the College has identified a top 10 list of actions that physician and their staff can do now to prepare. These include:

1. **Understand MACRA** – via any and all of the educational approaches described earlier.
2. **Meet CMS objectives for Meaningful Use (MU) of your EHR to qualify for the EHR Incentive Program for 2016.** This is critically important even now as MU will be rolled into the new MIPS program, with reporting for MIPS beginning as early as 2017 and having a certified EHR also will be a requirement for participation in an APM. While CMS has indicated some significant changes to MU are expected,¹⁰ effective use of an EHR is still a strong and necessary expectation for all practices.
3. **Understand and participate in the Physician Quality Reporting System (PQRS) program for 2016.** As with MU, PQRS will be rolled into the new MIPS program—and while it may undergo changes, ideally with some significant improvements related to the measures used and the administrative burden it requires, reporting and performing well on quality measures is fully expected within both the MIPS and APM pathways. Overall participation in PQRS is still just over 50 percent among clinicians¹¹—so it is critically important for more physicians to participate to ensure success.
4. **Implement a formal quality improvement process to improve your reported PQRS and MU quality measures. Ensure that your care adheres to accepted clinical guidelines.** Engaging in quality improvement and focusing on adherence to clinical guidelines will not only positively effect a physician’s quality score within MIPS, it is also expected to count toward the Clinical Quality Improvement Activities (CPIA) component of MIPS. Additionally, most current APMs in the marketplace, such as PCMHs and ACOs, call on physicians to actively engage in these efforts.

¹⁰ <https://blog.cms.gov/2016/01/12/comments-of-cms-acting-administrator-andy-slavitt-at-the-j-p-morgan-annual-health-care-conference-jan-11-2016/>

¹¹ https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_eRx_Experience_Report_zip.zip

5. **Review your Quality Resource Use Report (QRUR) for accuracy. Contact CMS if there are problems.** QRURs are reports supplied to physicians as part of the Value-Based Payment (VBP) Modifier program. This program is intended to provide comparative performance information to physicians as part of Medicare's efforts to improve the quality and efficiency of clinical care, and is also being rolled into the new MIPS program via the resource use component. QRURs, also known as Physician Feedback Reports, provide information to physicians and medical practice groups about their resource use and quality of care provided to their Medicare patients, including quantification and comparisons of patterns of resource use/cost among physicians and medical practice groups. These reports continue to be critical moving forward as MACRA requires CMS to provide feedback reports to physicians as part of MIPS, in order to facilitate physician awareness of their performance and ideally assist with identifying areas for improvement. By reviewing their QRURs now, physicians can be better informed of how their performance scores are currently calculated and how CMS is viewing their performance to date.
6. **Use a CMS certified vendor for collection of Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. This is required for practices with >100 clinicians, and optional for practices with 2-99 clinicians for 2016 reporting.** Along the lines of the actions already outlined above, improving and measuring patient experience will be an integral component of participation within both the MIPS and APM pathways of MACRA. Therefore, it is critical that practices begin now to gain experience in conducting patient experience surveys—this will not only serve to improve their scores in the new system, but can also facilitate greater engagement of patients and their families in quality improvement efforts by the practice.
7. **Understand the principles of the PCMH and begin implementing in your practice.** The PCMH model of care is strongly incentivized within both pathways of MACRA. In the MIPS program, physicians in practices that are determined to be a “certified” medical home will receive full credit within the CPIA component of their MIPS composite score and are also likely to score well on all of the other components—quality, resource use, and meaningful use of EHRs—given that they are already engaging in collecting, reporting on, and responding to these data. Likewise, within the APM pathway, physicians in PCMHs that are determined to be eligible APMs, will not be required to take on financial risk. This is a critical element of the law, as it

offers the opportunity for smaller and independent practices, who simply cannot bear financial risk beyond the still significant practice transformation costs, to become eligible APMs as PCMHs and reap the appropriate rewards for their efforts. A challenge that primary care practices face in the short term is that CMS has not yet defined how they will define “certified” for MIPS and APMs; however, there are overarching consistent principles across all of the available certification, recognition, and accreditation programs for PCMH that physicians and their care teams can begin implementing now. These principles include adopting new approaches to providing patient access, implementing team-based care approaches (e.g., team huddles), adopting and using innovative approaches to health information technology, and engaging in population management, among others.

8. **Participate in a “medical neighborhood” and provide care coordination to reduce unnecessary visits and testing.** The PCMH model is critically important on its own; however, to further improve care and have a greater impact on longitudinal patient outcomes and experience, specialty practices should begin now to engage with their colleagues as part of a patient-centered medical neighborhood. Within MACRA, physician participation in PCMH specialty practices is also strongly incentivized as part of MIPS. Like their PCMH counterparts, clinicians identified to be part of a “certified” PCMH specialty practice will receive full credit for the CPIA component. It is also anticipated that over time, physicians engaging in this model will be better positioned to participate in an eligible APM.
9. **Empanel and risk stratify your patient population, and implement care management for those at high risk for hospitalization or ER visits.** Empanelment is when a practice takes on assigning individual patients to individual primary care clinicians and care teams with sensitivity to patient and family preference—and is the basis for taking on meaningful population management.¹² Empanelment, along with implementing care management approaches, are practical steps that all practices can take to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need. It will ready clinicians and their teams to be successful across all components of MIPS and within APMs no matter how the regulations are constructed.

¹² <http://www.safetynetmedicalhome.org/change-concepts/empanelment>

- 10. Become educated on ACP's High Value Care recommendations and implement them in your practice to prevent unnecessary testing and procedures.** Taking the concepts of empanelment and care management one step further, the College recommends that all clinicians proactively understand what it means to provide high-value care and how they can implement those concepts within their practices. Again, this is something that can begin now and will be beneficial to physicians and their practices, but more importantly, to patients and their families.

To assist practices in taking their MACRA education to the next level and be able to achieve short term success on the top ten items listed above, as well as to thrive in the longer term as MACRA is implemented, the College offers a number of tools and services. These are outlined in greater detail below.

ACP Practice Advisor®

The ACP Practice Advisor¹³ is a premier online interactive tool that offers practices the ability to conduct significant, evidence-based quality improvement based on the most up-to-date clinical guidelines; improve performance on clinical quality measures; implement the principles of the PCMH and PCMH specialty practice models; and improve the overall management of their practice. The Practice Advisor currently contains 45 modules in the following categories:

- 1. Building the Foundation**

These modules address the key attributes and expectations of PCMHs according to the major national recognition and accreditation entities. This guidance is also applicable to all practices and specialties interested in providing patient-centered care, even if not seeking qualification as a PCMH.

- 2. Improving Clinical Care**

These modules help practices apply the attributes of patient-centered care to improve the health of people and populations with specific conditions or clinical concerns.

- 3. Managing Your Practice**

¹³ <https://www.practiceadvisor.org/>

These modules help practices deliver efficient and effective care by providing tools and resources that support the day-to-day operations of a well-functioning practice.

4. **Maintenance of Certification**

Each of these modules qualifies for 20 American Board of Internal Medicine (ABIM) Maintenance of Certification (MOC) Self-Evaluation of Practice Performance points.

5. **Specialty Practice Recognition**

These modules address the key attributes and expectations of specialty and sub-specialty PCMHs according to the National Committee on Quality Assurance (NCQA). This guidance is also applicable to all specialty and sub-specialty practices and specialties interested in providing patient-centered care, even if not seeking qualification as a PCMH.

These modules serve to educate and guide physicians and their care teams as they work to transform their practices in order to improve their ability to provide high quality, safe, efficient, effective, and timely patient centered care. The components of the modules consist of 1) evidence-based background information, 2) case studies that provide examples of how to implement these approaches in the practice setting, 3) ACP Practice Biopsy, an assessment of how the practice is doing, and 4) resources and tools to support implementation. The Case Study and Practice Biopsy focus on the processes that need to be implemented or enhanced to accomplish the transformation from volume based to value driven healthcare. Additionally, as noted above, selected Practice Advisor Modules have been developed to provide MOC credit to physicians for assessing how well a practice is performing with regard to specific clinical quality measures.

The Practice Advisor modules serve to facilitate practice transformation independent of any given payment model, but are clearly approaches that will ensure success within MACRA and beyond.

ACP High Value Care Initiative

ACP's High Value Care (HVC) initiative¹⁴ offers learning resources for clinicians and medical educators, including clinical guidelines, best practice advice, performance measurement, case studies and patient

¹⁴ <https://www.acponline.org/clinical-information/high-value-care>

resources on a wide variety of related topics. For clinicians, HVC offers resources to help implement HVC principles into practice and focus on optimal diagnostic and treatment strategies, based upon considerations of value, effectiveness, and avoidance of overuse and misuse. These resources include clinical practice guidelines, clinical guidance statements, and best practice advice, along with case studies and learning modules. For educators, the College provides a curriculum for educators, students and Subspecialty Fellows; courses for faculty; as well as a video to help teach faculty how to implement the High Value Care Curriculum. Finally, for patients ACP offers specific advice related to adult vaccines, lower back pain, diabetes and many other areas.

CMS' Transforming Clinical Practice Initiative – ACP's Support and Alignment Network Grant

The College is one of ten Support and Alignment Network (SAN) grants awarded by CMS to provide a system for workforce development, utilizing national and regional professional associations and public-private partnerships that are currently working in practice transformation efforts.¹⁵ SAN grants are part of the overarching CMS Transforming Clinical Practice Initiative (TCPI) effort, with the goal of supporting clinician practices through nationwide, collaborative, and peer-based learning networks that facilitate large-scale practice transformation. The College's work in this area will be focused on providing an array of tools and resources to support clinicians and practices as they transform from volume-based to value-based, patient-centered care—these tools include building out new modules within the Practice Advisor, offering High-Value Care case studies, and referring practices to Practice Transformation Networks (PTNs), which are peer-based learning networks designed to coach, mentor and assist clinicians in developing core competencies specific to practice transformation. While this effort is not directly tied to MACRA, this significant investment by ACP and the other SAN and PTN grantees will offer numerous practices across the country the support they need to be successful.

Quality Improvement Activities

ACP's Center for Quality leads a nationwide quality improvement network of ACP chapters, physicians, their health care teams, residency programs, and other health and quality systems. ACP Quality Connect, as it is called, currently focuses on diabetes, adult immunization, and chronic pain

¹⁵ <https://www.acponline.org/practice-resources/business-resources/payment/transforming-clinical-practice-initiative>

management. The peer network of nearly 2000 physicians and their teams in 19 states are working to improve management of chronic conditions while linking to multiple performance reporting requirements, including professional requirements for certification and payer-linked programs. More specifically, it has helped more than 200 practices submit for PQRS and Bridges to Excellence, plus earn MOC part IV credits. This program is also linked to ACP registries including the Genesis QCDR, described below, and the Diabetes Collaborative Registry.

Quality Reporting Registries: Genesis Registry and PQRS Wizard

The College has partnered with CE City to offer our members the ACP Genesis Registry^{TM, 16} 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 eMeasures across all 6 National Quality Strategy (NQS) domains. Calculated measures represent more than 123 million patient records. The Genesis Registry is also linked to ACP's growing area of clinical quality improvement programs, described above.

ACP also offers the PQRS Wizard¹⁷—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.

The Physician & Practice TimelineSM: Professional Requirements and Opportunities

The College has created The Physician and Practice Timeline¹⁸—an online tool that provides a helpful at-a-glance summary of upcoming important dates related to a variety of regulatory, payment, and

¹⁶ <https://www.medconcert.com/content/medconcert/Genesis/>

¹⁷ <https://acp.pqrswizard.com/default.aspx>

¹⁸ <https://www.acponline.org/practice-resources/regulatory-resources/physician-practice-timeline>

delivery system changes and requirements, including PQRS, the Value-Based Modifier Program, MU, Open Payments Program, transitional care management (TCM) codes, the chronic care management (CCM) code, and the advance care planning codes. The Timeline then links users to practical tools and resources to help them with successful participation—and users can choose to opt into a text alert system that will actively inform them of significant regulatory changes, new resources, and upcoming deadlines. This service will be evolving as MACRA is implemented to continue to provide practical updates and support for physicians and their care teams related to MIPS and APMs.

AmericanEHR Partners™

AmericanEHR Partners¹⁹ 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.

Patient-Care Resources

In addition to resources aimed at helping clinicians and their practices, the College has also developed information to help patients and their families understand health conditions and facilitate communication between patients and their healthcare team.²⁰ 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.

¹⁹ <http://www.americanehr.com/>

²⁰ <https://www.acponline.org/practice-resources/patient-care-resources-and-tools>

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.

Under Development – MACRA Guidance Tool

The College is in the process of developing an online tool to assess a clinician's practice, help them decide whether MIPS or APM payment track is the best choice for their practice, and point them to customized resources to facilitate implementation of changes to comply with MIPS or APM. The tool will gather the following information from the practice:

- practice description: type, size, structure, geography, patient demographics;
- current quality improvement, health information technology, resource use, and quality measurement activities; and
- readiness to take on new practice activities.

It will then direct them to targeted educational information and resources to facilitate success, including many of the tools and services outlined above. It is expected that this new tool will be online and available to ACP members by the end of 2016.

CONCLUSION

The College would again like to sincerely thank Chairman Pitts and Ranking Member Green for convening this hearing and for your shared commitment to ensure that the payment and delivery system reforms created under MACRA are implemented successfully and as intended by Congress. We appreciate the Committee inviting input from the physician community during the implementation process—and are extremely interested in continuing to work with Congress and with CMS to ensure that MACRA is a success. Our hope is that the information outlined today will provide the Committee with assurance that the College is committed to our support for MACRA, to providing constructive feedback to CMS and to educating and supporting physicians and other clinicians in their transition to value-based payment within Medicare FFS and beyond.