

REPORT 10 OF THE COUNCIL ON MEDICAL SERVICE (A-17)
Physician-Focused Payment Models: Reducing Barriers
(Reference Committee G)

EXECUTIVE SUMMARY

The Council on Medical Service initiated this report to provide an overview of challenges facing physicians in the transition to value-based payment models and particularly to Physician-Focused Payment Models (PFPMs). This report follows from Council on Medical Service Report 9-A-16, “Physician-Focused Alternative Payment Models,” which was adopted at the 2016 Annual Meeting of the House of Delegates and created guiding foundational policy to support the appropriate shift to physician-focused Alternative Payment Models (APMs).

While the Council recognizes that APMs have potential to provide higher quality care at lower costs, physicians often face barriers in the current payment system that prevent them from seizing upon new opportunities. Specifically, this report attempts to address some of the barriers in the current payment system that preclude or hamper the ability of physicians to adopt innovative payment models. Shifting the health care payment and delivery system requires not only uprooting and changing current aspects of the system but also additional technical assistance and capabilities to support such a shift. To that end, this report focuses on barriers to the development and implementation of APMs including the limitations of existing health information technology (IT) capabilities, resource use measures, and resource use challenges including risk adjustment, attribution, and performance target setting.

With the completion of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) final rule, now is a critical time for physicians to implement APMs as MACRA begins to take effect. Accordingly, the Council offers a set of recommendations intended to address the barriers that interfere with the shift to value-based payment. The recommendations are consistent with AMA policy and significant ongoing advocacy efforts. The Council recognizes that the need for technical assistance and health IT functionality and affordability place enormous stress on physicians and inhibit PFPM participation and suggests a set of recommendations to address these issues. Additionally, the Council recommends working with stakeholders to bring about changes to resource use measurement, including risk adjustment, attribution, and performance targets in order to better support improved care delivery and patient outcomes delivered at a lower cost. Physicians must be equipped to shape payment reforms appropriately, and the Council is hopeful that its recommendations will help physicians as they develop and participate in value-based payment and delivery reform.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 10-A-17

Subject: Physician-Focused Alternative Payment Models: Reducing Barriers

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Referred to: Reference Committee G
(J. Clay Hayes, MD, Chair)

1 At the 2016 Annual Meeting, the House of Delegates adopted the recommendations of Council on
2 Medical Service Report 9-A-16, “Physician-Focused Alternative Payment Models,” which created
3 guiding foundational policy to support the appropriate shift to physician-focused Alternative
4 Payment Models (APMs) (see Policy H-385.913). As payment models take effect and evolve, the
5 American Medical Association (AMA) must focus not only on physician awareness and
6 understanding of APMs but also on their implementation and sustainability. To that end, this report
7 identifies current barriers to the development and implementation of APMs including the
8 limitations of existing health information technology (IT) capabilities, a dearth of valid and reliable
9 resource use measures, and current challenges such as risk adjustment, attribution, and performance
10 target setting.

11
12 This report, initiated by the Council, provides an overview of the Medicare Access and CHIP
13 Reauthorization Act of 2015 (MACRA) provisions; outlines a number of barriers preventing the
14 development and implementation of APMs; details the work of the Physician-focused Payment
15 Model Technical Advisory Committee (PTAC) to the Secretary of the US Department of Health
16 and Human Services (HHS); highlights a number of Physician-Focused Payment Model (PFPM)
17 proposals submitted to the PTAC; describes an APM being implemented across the country;
18 summarizes relevant policy; and presents policy recommendations to help alleviate the enumerated
19 barriers.

20 21 BACKGROUND

22
23 MACRA repealed the Sustainable Growth Rate (SGR) formula and the constant threat of payment
24 cuts to which physicians were subject under the SGR. MACRA is separate from yet builds upon
25 the Affordable Care Act’s (ACA) focus on the shift to value-based payment. Of note is that
26 MACRA not only repealed the SGR but also changed the way Medicare would link physician
27 payments to quality improvement and use of technology moving forward. It creates new ways for
28 the Medicare program to adjust physician payments for the care they provide to Medicare
29 beneficiaries through MACRA’s Quality Payment Program (QPP). The QPP has two participation
30 tracks: the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models
31 (APMs).¹

32
33 The first QPP track, MIPS, will provide annual updates to physicians starting in 2019 based on
34 their performance in four categories: quality (replaces the Physician Quality Reporting System),

1 cost (replaces the Value-Based Modifier), improvement activities (new), and advancing care
2 information (replaces Meaningful Use of an electronic health record system).² Instead of three
3 separate programs, MIPS is intended to be one cohesive program to incentivize and reward
4 physicians who meet or exceed performance thresholds and improve care.

5
6 The second QPP track is participation in Advanced APMs. APMs are intended to fundamentally
7 change how care is delivered and paid for. Examples of APMs include accountable care
8 organizations (ACOs) and other demonstration programs that have been created under the Centers
9 for Medicare & Medicaid Services' (CMS) Center for Medicare & Medicaid Innovation (CMMI).³
10 In addition to the models that are currently available, MACRA encourages the development of
11 PFPMs, which are the focus of this report. PFPMs are an APM wherein Medicare is the payer,
12 physician group practices or individual physicians are APM participants, and the focus is on the
13 quality and cost of physician services.⁴

14
15 MACRA established the PTAC, an 11-member independent federal advisory committee, to review,
16 assess, and potentially recommend PFPM proposals submitted by stakeholders to the committee
17 based on certain criteria defined in regulations. After reviewing the PTAC's recommendations,
18 CMS is required to post a detailed response on its website. After providing an opportunity for
19 public comments on a draft Request for Proposals (RFP) in August 2016, the PTAC issued an RFP
20 and guidance on the types of proposals it is seeking in November and has been accepting PFPM
21 proposals for its review since December 2016.

22 23 OPPORTUNITIES

24
25 Although the ACA and MACRA set goals to accelerate the development and implementation of
26 innovative payment and delivery models, the majority of physicians do not yet have the tools and
27 opportunities necessary to participate in APMs that support their efforts to improve care while
28 reducing costs. For example, it is estimated that only 26 percent of physicians are part of a medical
29 home, and 32 percent of physicians are part of a Medicare ACO.⁵ Despite numerous demonstration
30 projects, most physicians, including primary care and other specialists, still lack access to APM
31 participation.

32
33 MACRA's focus on PFPMs creates an opportunity to accelerate the implementation of APMs by
34 expanding the number of eligible APMs and imparting them with the flexibility physicians need to
35 help drive the shift toward improved value. Having several common frameworks for new APMs
36 will not only make it easier for particular specialties to create payment models that match their
37 needs, but should also make it easier for payers to implement payment models for multiple
38 specialties and various practice types and settings. With the first APM performance period under
39 the MACRA final rule starting in January 2017, now is a critical time for physicians to design and
40 implement APMs in their practices. PFPMs provide a unique opportunity for physician
41 organizations, including group practices and specialty and state medical societies, to have a key
42 role in the development of new APMs, and for the AMA to aid members of the Federation in
43 taking advantage of this opportunity.

44 45 BARRIERS

46
47 The overarching goal of payment reform is widely agreed to be delivery of high quality care in a
48 cost efficient manner to improve patient outcomes. However, there are currently significant
49 challenges to achieving that goal. APMs can only achieve their desired objective if the multitude of
50 issues impeding their development and adoptability are addressed. Health IT capabilities and
51 measurement challenges such as appropriate risk stratification and adjustment methods, attribution,

1 and performance targets may inhibit APM development and discourage participation. The Council
 2 intends to address these barriers in the report to enable widespread development and adoption of
 3 PFPMs across physician practice size, specialty, and geographic location.

4
 5 *Health IT*

6
 7 Poorly functioning health IT continues to be one of the greatest drags on efficiency and satisfaction
 8 in the practice of medicine and is therefore a significant barrier to the development and
 9 implementation of care delivery and payment reform. PFPMs depend on access to high quality,
 10 real-time actionable data at the point of care. Physicians' readiness to participate in PFPMs hinges
 11 on health IT systems that support and streamline participation. The availability and affordability of
 12 electronic health information that tracks and informs care has been a challenge since the advent of
 13 health IT. Without the appropriate tools, physicians will continue to struggle to track the metrics
 14 necessary to inform and improve care delivery. Physicians must have the guidance and technical
 15 assistance to meaningfully participate in PFPMs.

16
 17 Lack of interoperability also hinders value-based care through PFPMs. Electronic health record
 18 (EHR) systems should facilitate connected health care across settings and enable the exporting of
 19 data and the ability to properly incorporate data from other systems. Connecting EHRs to external
 20 registries is one possible barrier due to backend technology that is often necessary for connectivity
 21 and may not exist, or in cases where it does exist, is often cost prohibitive.⁶ Clinical registries and
 22 Qualified Clinical Data Registries (QCDRs) have the potential to promote quality improvement
 23 and enhance patient safety and care. QCDRs are platforms that collect clinical data, calculate
 24 performance on quality measures and submit results to entities such as CMS with the overarching
 25 goal of improving the quality of care provided to patients. Since the passage of MACRA, CMS has
 26 encouraged reporting through QCDRs given their potential for advancing quality care. QCDRs
 27 enable physicians to report on quality measures that are outcomes oriented and may be more
 28 relevant to a physician's patient population as compared to traditional PQRS measures. However,
 29 to achieve the shared goal of greater QCDR participation, QCDRs need flexibility to incorporate
 30 measures that are tailored to their participating specialties. QCDRs are a fundamental aspect of a
 31 learning-based care environment since they allow tracking of measures, learning from the
 32 performance results in real-time, and adjusting clinical practice accordingly.

33
 34 Data blocking, a sub-component of interoperability, continues to be an obstacle to the meaningful
 35 use of health IT. PFPMs only work efficiently when physicians have access to health information
 36 in real-time and in a coordinated manner. However, physicians continue to experience difficulties
 37 in transmitting and sharing patient health information. Barriers to interoperability and access to
 38 patient data must be overcome if APMs, including PFPMs, are to enjoy widespread acceptance and
 39 participation.

40
 41 In order to realize the benefits of a learning-based health care system, patients and physicians must
 42 have access to their complete patient record. The 21st Century Cures Act, which was signed into
 43 law in December 2016, aims to address some of the health IT challenges outlined above and to
 44 promote information sharing and interoperability.⁷ Among other things, the 21st Century Cures Act
 45 calls for the creation of a reporting system to gather information about EHR usability and
 46 interoperability; supports the creation of a digital health care directory to facilitate exchange;
 47 encourages the exchange of health information between registries and EHR systems; and grants the
 48 HHS Office of the Inspector General authority to assign penalties for blocking the sharing of
 49 electronic health records.⁸ If properly implemented, the 21st Century Cures Act provides a path
 50 forward for increased interoperability and clinician access to useable data to inform care.

1 *Risk Adjustment*

2

3 The resources needed to achieve appropriate patient outcomes during an episode of care depend
 4 heavily on the individual needs of the patient as well as their ability to access care and properly
 5 adhere to prescribed treatment plans.⁹ Many risk adjustment methods only explain a small percent
 6 of the total variation, and they are focused on variation in spending, not on patient factors. Current
 7 risk adjustment methods are designed for a health plan's entire covered population, not the
 8 subpopulations of patients with a particular condition. Moreover, cost measures and benchmarks
 9 are often based on historical information on patient characteristics, not the most current
 10 information on health problems that affect the services patients need. As a result, risk adjustment
 11 based on prior claims data may not account for significant changes in the patient's health status.
 12 Further exacerbating data deficiencies is that most risk adjustment systems give little or no
 13 consideration to the factors other than health status that can affect patient needs, such as functional
 14 limitations and access to health care services.

15

16 Some risk adjustment methods do not take into account disease stages, such as cancer or kidney
 17 disease or glaucoma, or functional status, nor do they account for the factors that affect whether a
 18 particular patient is a favorable or poor candidate for a particular treatment. An additional concern
 19 is that most risk adjustment methods do not adequately account for socio-demographic factors.
 20 Research is emerging demonstrating the influence of socio-demographic factors, such as
 21 community supports, on the cost and outcomes of care. Flawed risk adjustment methods have the
 22 unwanted effect of inappropriately penalizing the physicians and health systems caring for sicker
 23 patients and individuals with socio-demographic challenges while rewarding those who do not care
 24 for these patients. As an unintended consequence, it may be harder for higher-need patients to
 25 access care and for physicians caring for these patients to maintain a sustainable practice.¹⁰

26

27 *Attribution*

28

29 Current retrospective statistical attribution methodologies often fail to accurately assign to
 30 physicians the services they delivered.¹¹ The purpose of attribution and corresponding performance
 31 measures is to ensure that physicians are held accountable for the costs they can control but not for
 32 costs they cannot. Use of an attribution method that assigns total costs to physicians regardless of
 33 their contributions to those costs is improper. Spending on complications and preventive conditions
 34 may be improperly assigned to the physicians who treated the problems.

35

36 Attribution methods that rely solely on claims are problematic. For example, in the Comprehensive
 37 Primary Care Plus (CPC+) APM, a patient can be attributed to a physician if the physician is
 38 billing for Chronic Care Management (CCM), which is a non-face-to-face service. However,
 39 physicians participating in CPC+ generally cannot bill for CCM for a CPC+ beneficiary.
 40 Accordingly, if physicians provide more non-face-to-face services and fewer visits, it is possible
 41 that patients will be inappropriately attributed to different physicians.

42

43 Various attribution methods could provide mixed signals to physicians as to who is actually
 44 responsible for delivering efficient care. The concern regarding accountability is exacerbated if
 45 some of the clinicians caring for a CPC+ participant's patients are unaffiliated with CPC+ and lack
 46 the same incentives to coordinate care and making care coordination more challenging. The delay
 47 in providing physicians with lists of attributed patients in real-time also stifles timely care
 48 coordination.

1 *Performance Targets*

2
 3 Performance targets refer to quality metrics upon which physicians are measured. It is a priority to
 4 ensure performance targets are not unduly burdensome for physicians, particularly those in small
 5 practices and solo physicians, as they transition to value-based care and try implementing APMs.
 6 Unachievable performance targets may discourage physicians from developing and implementing
 7 PFPMs. Therefore, performance targets must be set reasonably such that Medicare savings may be
 8 realized while practice risk is reasonable. Payment rates for services should be set so that practices
 9 have the resources necessary to meet performance targets and are able to succeed under a new
 10 model. Importantly, physicians must receive data on how much is currently being spent on a
 11 particular condition and how much spending is potentially avoidable through the APM. Developing
 12 PFPMs is impossible without answering these questions so that realistic performance targets can be
 13 set.

14
 15 WORK OF THE PTAC

16
 17 The PTAC serves an important advisory role in the implementation of PFPMs, and will be
 18 instrumental in achieving the goal of developing more PFPMs. The PTAC is charged with seeking
 19 the following types of models for recommendation to the Secretary of HHS:

- 20
 21 • Payments designed to enable an individual, eligible professional, or group of eligible
 22 professionals to improve care for patients who are receiving a specific treatment or
 23 procedure. These “treatment-based payments” could focus only on services delivered
 24 on the day(s) of treatment or on services delivered during a longer episode of care;
 25 • Payments designed to enable an individual, eligible professional, or group of eligible
 26 professionals to improve care during a period of time for patients who have a specific
 27 health condition or combination of conditions. These “condition-based payments”
 28 could focus on either acute conditions or chronic conditions;
 29 • Payments designed to enable teams of eligible professionals to deliver more
 30 coordinated, efficient care for patients who have a specific condition or are receiving a
 31 specific treatment or procedure;
 32 • Payments designed to improve the efficiency of care and/or outcomes for patients
 33 receiving both services delivered by physicians or other eligible professionals and
 34 related services ordered by eligible professionals that are delivered by other providers;
 35 • Payments designed to enable physicians or other eligible professionals to improve care
 36 for particular subgroups of patients (e.g., patients with a severe form of a condition,
 37 patients who have an early stage of a condition where progression can be more easily
 38 prevented, patients who need special services after treatment, or patients living in
 39 frontier or rural communities);
 40 • Payments designed to enable a primary care physician or a multi-specialty group of
 41 eligible professionals to improve care for most or all of the health conditions of a
 42 population of patients, or to prevent the development of health problems in a
 43 population of patients with particular risk factors;
 44 • Revisions to the codes and fee levels for a broad range of services delivered by
 45 physicians and other eligible professionals that are designed to support delivery of a
 46 different mix of services in conjunction with accountability for measures of utilization,
 47 spending, or outcomes for a group of patients; and
 48 • Payments in which the amount of payment depends on patient outcomes, with or
 49 without changes to the units of payment for individual physicians or other eligible
 50 professionals.

1 Pursuant to MACRA, the Secretary was required to establish criteria for PFPMs, and these criteria,
2 which were included in the MACRA final regulations, will be used by the PTAC to evaluate the
3 proposals it receives:

- 4
- 5 • *Value over volume*: Provide incentives to practitioners to deliver high-quality health
6 care;
- 7 • *Flexibility*: Provide the flexibility needed for practitioners to deliver high quality health
8 care;
- 9 • *Quality and Cost*: PFPMs are anticipated to improve health care quality at no
10 additional cost, maintain health care quality while decreasing cost, or both improve
11 health care quality and decrease cost;
- 12 • *Payment methodology*: Pay APM participants with a payment methodology designed
13 to achieve the goals of the PFFM criteria. Addresses in detail through this
14 methodology how Medicare and other payers, if applicable, pay APM participants,
15 how the payment methodology differs from current payment methodologies, and why
16 the PFFM cannot be tested under current payment methodologies;
- 17 • *Scope*: Aim to either directly address an issue in payment policy that broadens and
18 expands the CMS APM portfolio or include APM participants whose opportunities to
19 participate in APMs have been limited;
- 20 • *Ability to be evaluated*: Have evaluable goals for quality of care, cost, and any other
21 goals of the PFFM;
- 22 • *Integration and Care Coordination*: Encourage greater integration and care
23 coordination among practitioners and across settings where multiple practitioners or
24 settings are relevant to delivering care to the population treated under the PFFM;
- 25 • *Patient Choice*: Encourage greater attention to the health of the population served
26 while also supporting the unique needs and preferences of individual patients;
- 27 • *Patient Safety*: Aim to maintain or improve standards of patient safety; and,
28 • *Health Information Technology*: Encourage use of health IT to inform care.¹²
29

30 The PTAC intends to evaluate the degree to which stakeholder's proposed models satisfy the
31 Secretary's criteria and make recommendations regarding the proposed model including whether to
32 test on a limited scale, implement, implement with high priority, or not recommend. Proposed
33 PFPMs may be submitted to the PTAC on an ongoing basis.

34 35 PTAC PROPOSALS

36
37 As previously stated, the PTAC began accepting PFFM proposals on December 1, 2016. At the
38 time that this report was written, seven proposals and numerous letters of intent have been
39 submitted to the PTAC and are available on its website ([https://aspe.hhs.gov/proposal-submissions-
40 physician-focused-payment-model-technical-advisory-committee](https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee)) for public comment. At its April
41 meeting, the committee reviewed three of the proposals and recommended two of the proposals for
42 limited-scale testing. These two proposals are briefly discussed below: the American College of
43 Surgeons-Brandeis proposal and Project Sonar, a model submitted by the Illinois Gastroenterology
44 Group and SonarMD, LLC.

45 46 *American College of Surgeons-Brandeis*

47
48 The ACS-Brandeis APM is an episode-based payment model. The model is built on an updated
49 version of the episode grouper for Medicare software currently used by CMS for measuring
50 resource use. The grouper processes Medicare claims data using clinical specifications to create

1 condition-specific episodes to assess utilization and costs. The patient-focused philosophy of both
2 the grouper and APM recognizes that surgical care is team-based, and that coordination with
3 medical specialists, primary care and all the other segments of the delivery system involved plays
4 an important role in improving outcomes. The model does not require hospitalization, which allows
5 for inclusion of procedures performed in the outpatient setting and possible expansion to include
6 acute and chronic conditions.

7
8 *Project Sonar*

9
10 The 20 gastroenterology practices that have participated in the Project Sonar model to date have
11 achieved significant improvements in quality and outcomes for patients with Crohn's disease while
12 also lowering costs. The health plan has stated that the model is saving significant amounts of
13 money due to decreased hospitalizations. Project Sonar achieved these improvements using a care
14 pathway and clinical decision tool developed by the American Gastroenterological Association.
15 Project Sonar's innovative technical solutions engage patients in a monthly process of reporting to
16 their gastroenterologist on their symptoms and feelings, and they then receive an immediate action-
17 focused response if indicated by the reported symptoms. The project has been effective in reducing
18 hospital admissions and emergency department visits for patients with Crohn's disease, especially
19 those who demonstrate the most engagement in their own health care by responding to the monthly
20 "pings." Project Sonar is more than a model way of improving care for patients with Crohn's
21 disease. It also has the potential to support better care for patients with other kinds of chronic
22 health problems that require close monitoring to avoid hospitalizations and therefore demonstrates
23 a means for specialist physicians who have had very few opportunities to participate in APMs to
24 date to effectively do so.

25
26 EXAMPLE OF AN APM: CPC+

27
28 As previously noted, CPC+ is an example of an Advanced APM already implemented in practices
29 across the country. CPC+ is a primary care medical home model that aims to strengthen primary
30 care through payment reform coupled with delivery transformation. The CPC+ model focuses on
31 strategies to promote population health and chronic disease management techniques to encourage
32 more coordinated care. There are two tracks of the CPC+ program with different levels of risk and
33 potential upside. In both tracks, CPC+ includes three payment elements. First, practices receive a
34 risk adjusted non-visit-based care management fee paid per beneficiary per month, which is
35 intended to pay for services that fall outside the traditional physician visit such as patient education
36 and medication management and adherence support. Second, CPC+ uses a performance-based
37 incentive payment that is based on how well a practice performed on patient experience of care
38 measures, clinical quality measures, and utilization measures that drive total cost of care. Finally,
39 practices receive a payment under the Medicare Fee Schedule. In CPC+ Track 1, practices continue
40 to bill and receive fee-for-service (FFS) payments as usual. However, in CPC+ Track 2, practices
41 receive a hybrid payment meaning they receive a Comprehensive Primary Care Payment (CPCP)
42 and a reduced FFS payment. This hybrid model is intended to account for CMS shifting a portion
43 of Medicare FFS payments into CPCP, which are paid in a lump sum on a quarterly basis. Because
44 it is the expectation that Track 2 practices will increase the breadth and depth of services offered,
45 the CPCP amounts will be larger than the FFS payment amounts they are intended to replace.

46
47 RELEVANT AMA POLICY

48
49 At the 2016 Annual meeting, the House of Delegates adopted the recommendations of Council on
50 Medical Service Report 9-A-16, "Physician-Focused Alternative Payment Models," which created
51 guiding foundational policy (H-385.913) to support the appropriate shift to physician-focused

1 APMs. Policy H-385.913 promulgated goals for physician-focused APMs, developed guidelines
2 for medical societies and physicians to begin identifying and developing APMs, and encouraged
3 CMS and private payers to support assistance to physician practices working to implement APMs.
4 The policy has been influential in related AMA advocacy thus far, which has included development
5 of extensive comments on the MACRA proposed and final rules and responding to draft documents
6 from the PTAC and proposed models from CMMI. The AMA has a key role in helping physicians
7 develop and participate in PFPMs.

8 The AMA has extensive policy related to physician-led payment reform models. AMA policy is
9 committed to promoting physician-led payment reform programs that serve as models for others
10 working to improve patient care and lower costs (Policy D-385.963). Policy H-390.844 emphasizes
11 the importance of physician leadership and accountability to deliver high quality and value to
12 patients. In transitioning from the SGR, the AMA advocates for providing opportunities for
13 physicians to determine payment models that work best for their patients, their practices, and their
14 regions (Policy H-390.844). Policy D-390.953 directs the AMA to advocate with CMS and
15 Congress for APMs developed in concert with specialty and state medical organizations. Policy H-
16 450.931 recognizes that physicians will need assistance transitioning to APMs.

17
18 Policy H-390.849 directs the AMA to advocate for the adoption of physician payment reforms that
19 promote improved patient access to high-quality and cost effective care and that such reforms be
20 designed with input from the physician community. It calls for adequate risk adjustment
21 methodologies and encourages attribution processes that emphasize voluntary agreements between
22 patients and physicians. The policy also states that reformed payment rates must be sufficient to
23 maintain a sustainable medical practice and that payment reform implementation should be
24 undertaken within a reasonable timeframe and with adequate assistance.

25
26 The AMA also has significant and comprehensive policy on health IT. Policy D-478.972 calls for
27 efforts to accelerate development and adoption of universal, enforceable EHR interoperability
28 standards for all vendors; supports and encourages Congress to introduce legislation to eliminate
29 unjustified information blocking and excessive costs which prevent data exchange; eliminate
30 pricing barriers to EHR interfaces and connections to health information exchanges; and continue
31 to promote interoperability of EHRs and clinical registries. Policies D-478.995 and D-478.996 echo
32 this commitment to work towards interoperability while mitigating the financial burden on
33 physicians. Policy H-450.933 encourages efforts to develop and fund clinical data
34 registries; supports flexibility in the development and implementation of clinical data registries;
35 encourages physicians to participate in clinical data registries; and advocate for and support
36 initiatives that minimize the costs of physician participation in clinical data registries. Policy H-
37 478.984 directs the AMA to advocate for the adoption of federal and state legislation and
38 regulations to prohibit health care organizations and networks from blocking the electronic
39 availability of clinical data.

40 41 AMA ACTIVITY

42
43 The AMA continues to work to prepare physicians for the implementation of MACRA. The AMA
44 has been active in educational activities including webinars and regional conferences for physicians
45 and staff and will be continuing these activities. Recent AMA advocacy activity has called for
46 improvements in the methodologies behind APMs to reduce practice barriers and enable more
47 physicians to participate. Such areas for improvement in methodology include performance targets,
48 risk adjustment, and attribution. The AMA recognizes that proper methodologies ensure that the
49 appropriate patients are participating in APMs and that the APM is designed in such a way that
50 prioritizes the patient's needs. Improving resource use (cost) measurement is an important focus
51 moving forward to ensure that the measures used compliment and support APMs.

1 The AMA has released new tools and resources to help physicians prepare. One important aim of
2 the new tools is to ease the transition of qualified physicians to the QPP and ensure their practices
3 remain sustainable moving forward. The new resources include the AMA Payment Model
4 Evaluator, AMA Steps Forward™ modules, and a series of ReachMD podcasts.

5
6 The AMA Payment Model Evaluator (<https://apps.ama-assn.org/pme/#/>) is an innovative tool
7 offering initial assessments to physicians so they can determine how their practices will be
8 impacted by MACRA and QPP, and how they can prepare for the 2017 performance year and
9 beyond. Developed with the expertise of physicians and input from partners, the tool gives
10 physicians and their staff a brief assessment of their practices, as well as relevant educational and
11 actionable resources. Once physicians and medical practice administrators complete the online
12 questionnaire, they receive an individualized practice profile that provides guidance on what QPP
13 path appears to be best for them (MIPS vs Advanced APMs) and how they can best succeed. The
14 AMA will continually update the Payment Model Evaluator to respond to regulatory changes and
15 to keep practices up to date throughout the new payment and care delivery reform process. The tool
16 is free to all physicians and their practice administrators.

17
18 The AMA STEPS Forward™ (<https://www.stepsforward.org/>) collection of practice improvement
19 modules has new MACRA-specific tools. Accurate and successful reporting on quality metrics is
20 crucial to the new Medicare payment system, both in the current Physician Quality Reporting
21 System program and under MACRA's new QPP. Effectively leveraging health IT to track practice
22 metrics is crucial in the evaluation of proposed PFPs to ultimately improve care. Each STEPS
23 Forward module focuses on a specific challenge and offers real-world solutions, steps for
24 implementation, case studies, downloadable tools and resources and an opportunity for continuing
25 education credit. Physicians and their practice staff can use these to improve practice efficiency and
26 ultimately enhance patient care, physician satisfaction and practice sustainability. The full
27 collection, which now includes more than 40 modules, has a variety of tools that will help
28 physicians and their practices, including:

- 29
- 30 • Implementing team-based care;
- 31 • Electronic health record selection and implementation;
- 32 • Preparing practices for value-based care;
- 33 • Implementing team documentation; and
- 34 • Quality Reporting and the importance of Qualified Clinical Data Registries (QCDRs) in
35 maximizing your success.
- 36

37 The AMA launched a ReachMD podcast series titled *Inside Medicare's New Payment System*
38 (<https://reachmd.com/programs/inside-medicare-new-payment-system/>). Several physicians who
39 have been instrumental in developing and implementing APMs are featured. The series also
40 includes podcasts with former CMS acting administrator Andy Slavitt; 2016-2017 AMA President
41 Dr. Andrew Gurman; and AMA staff experts.

42
43 Additionally, the AMA is undertaking significant work to improve health IT interoperability. The
44 AMA is working to convene the industry around a solution for interoperability that will support
45 data access to empower patients and clinicians.

46 47 AMA ADVOCACY ON MACRA APMs

48
49 The biggest APM problem in the proposed regulations for the QPP was the proposed definition of
50 "more than nominal financial risk," which was set at four percent of total Medicare spending on the

1 APM's patients. As spending on physician services is a small fraction of total spending, this
2 definition would have required physicians in APMs to take risk for hospital and other costs that are
3 outside their control and for which many practices receive no revenues. Instead, the AMA
4 successfully urged CMS to allow APM financial risk to be defined as a percentage of the APM
5 practices' revenues. The final rule set the standard at eight percent of revenues. In APMs that
6 define financial risk as a percentage of total spending, the final regulation lowered the minimum
7 percentage from four to three.

8 AMA comments also addressed the need to provide more credit for APM participation in the
9 improvement activities (IA) component of MIPS. While the proposed rule would have allowed full
10 credit for medical home participation, as required by MACRA, it only would have provided 50
11 percent IA credit for other APMs. As the AMA advocated, other APMs will also now provide full
12 credit in IA. Additionally, CMS responded to AMA comments by expanding the number of
13 medical homes that can be recognized under IA. Finally, whereas the proposed rule indicated that
14 the requirement for APM participants to use certified EHRs would increase from 50 to 75 percent
15 in future years, the final rule maintained the 50 percent requirement.

16
17 Comments on the final rule sought additional APM policy changes in future MACRA rulemaking.
18 For example, while the final rule set the revenue threshold at eight percent to meet financial risk
19 requirements, it indicated that it could be increased to 15 percent in 2019 and later years. The AMA
20 is advocating that the standard remain at eight percent. The AMA is also calling for the lower
21 financial risk requirements available for patient-centered primary care medical homes be extended
22 to specialty medical homes.

23
24 AMA advocacy efforts are also focused on the PTAC and PFPMs. The AMA attends and makes
25 public comments at meetings of the PTAC, submits comments on its draft documents and
26 stakeholder proposals, and works with specialty societies developing PFPM proposals to help
27 address challenges they face in APM design. To that end, the AMA convened an APM workshop in
28 Washington DC on March 20, 2016 to bring together many of the leading physicians who are
29 working on PFPM proposals to discuss potential solutions to these issues.

30 31 DISCUSSION

32
33 With the publication of the MACRA final rule, now is a critical time for physicians to implement
34 APMs as MACRA begins to take effect. While APMs have the potential to shape the future of
35 health care delivery and drive innovation, many obstacles to participation remain. The challenges
36 identified in this report are ripe for improvement. The AMA has a key role in helping physicians
37 navigate toward full and efficacious implementation of APMs, and helping physicians tackle these
38 obstacles is critical to physicians' success in new payment models. By addressing process barriers,
39 the AMA can help physicians work within the rules in MACRA legislation and regulations to
40 develop and implement new and feasible payment models tailored to their practices and patient
41 populations.

42
43 As MACRA implementation moves forward, it is vital for physicians to take a leadership role to
44 ensure that future changes fulfill the promise of delivering better care at lower costs in ways that
45 are financially viable for physician practices that vary in size and by specialty. The AMA is
46 uniquely qualified to help physicians shape this transition and ensure sustainable success through
47 targeted advocacy efforts and creation of physician-specific resources and tools. Major challenges
48 remain on the path to achieving value-based care, and the AMA and physicians must remain at the
49 forefront.

1 Health IT has the capacity to yield great change in health care that delivers improved health
2 outcomes. However, while it promises a future of connectedness and improved quality, challenges
3 remain in bridging the gap between data silos and full interoperability. The Council believes that
4 CMS must expand technical assistance for practices, ensure that the complex backend IT systems
5 required to receive clinician data are available and affordable, and enable systems to participate in
6 data exchange and provide physicians with useful reports and analyses based on the data provided.
7 Additionally, although the 21st Century Cures Act includes numerous provisions intended to
8 improve health IT, the Council believes that physicians must be diligent in ensuring such
9 provisions are promptly implemented.

10
11 Flawed risk adjustment methods can have the effect of inappropriately penalizing physicians who
12 care for sicker patients or those caring for patients whose socio-demographic status makes it
13 difficult to achieve the health outcomes they deserve. As such, the Council suggests alternative
14 approaches be explored in which the physician managing a patient's care can contribute additional
15 information that may not be available in existing risk adjustment methods and that can help risk
16 stratify patients appropriately. Additionally, to mitigate the possibility of physicians being
17 inappropriately penalized for caring for patients with socio-demographic challenges, the Council
18 suggests urging CMS to identify new data sources to enable adequate consideration of non-clinical
19 (e.g., socio-demographic) factors that contribute to a patient's state of health and account for
20 treatment success.

21
22 Attribution is intended to ensure that physicians are held accountable for the costs that they can
23 control. However, current attribution methods often fail to properly assign accountability for a
24 service to the appropriate physician, and the Council suggests policy to alter attribution methods so
25 that accountability for spending and quality is accurate. Attribution methods must complement and
26 support APMs by being based on the actual nature of the relationship between physician and
27 patient.

28
29 It is important that performance targets do not prevent physicians, particularly those in small, solo,
30 and rural practices, from participating in an APM. There is concern that stringent performance
31 targets may be unduly burdensome to physicians, particularly because not all consequences,
32 intended or not, of MACRA are yet known. Therefore, the Council suggests policy ensuring
33 performance targets are set reasonably. As a prerequisite to realizing Medicare savings, physicians
34 must receive data on how much is currently being spent on a particular condition and how much of
35 that spending is potentially avoidable through an APM. Such information is critical both to
36 physicians designing PFPs and to those considering whether participation is appropriate for their
37 practice.

38
39 Though the transition to value-based payment may be difficult, the Council believes that with a
40 united physician voice and strong leadership, payment reform will allow physicians to provide
41 higher quality care to patients and have sustainable practices. In this report, the Council offers a
42 set of recommendations intended to address some of the barriers that interfere with the shift to
43 value-based payment. These recommendations are consistent with AMA policy and significant
44 ongoing advocacy efforts. The Council recognizes that the need for technical assistance and health
45 IT functionality and affordability place enormous stress on physicians and inhibit PFP
46 participation. Additionally, the Council identifies resource use measurement, including risk
47 adjustment, attribution, and performance targets, as areas where improvements can be made.
48 Physicians must be equipped to shape payment reforms appropriately, and the Council is hopeful
49 that its recommendations will help physicians as they develop and participate in value-based
50 payment and delivery reform.

1 RECOMMENDATIONS

2
3 The Council on Medical Service recommends that the following be adopted and that the remainder
4 of the report be filed:

- 5
6 1. That our American Medical Association (AMA) reaffirm Policy H-385.913 promulgating
7 goals for physician-focused alternative payment models (APMs), developing guidelines for
8 medical societies and physicians to begin identifying and developing APMs, and
9 encouraging the Centers for Medicare & Medicaid Services (CMS) and private payers to
10 support technical assistance to physician practices working to implement APMs. (Reaffirm
11 HOD Policy)
12
- 13 2. That our AMA reaffirm Policy D-478.972 on electronic health record (EHR)
14 interoperability calling for the elimination of unjustified information blocking and
15 excessive costs which prevent data exchange and continuing efforts to promote
16 interoperability of EHRs and clinical registries. (Reaffirm HOD Policy)
17
- 18 3. That our AMA reaffirm Policy H-478.984 advocating for the adoption of federal and state
19 legislation and regulations to prohibit health care organizations and networks from
20 blocking the electronic availability of clinical data. (Reaffirm HOD Policy)
21
- 22 4. That our AMA reaffirm Policy H-450.933 encouraging efforts to develop and fund clinical
23 data registries and supporting flexibility in the development and implementation of clinical
24 data registries. (Reaffirm HOD Policy)
25
- 26 5. That our AMA encourage physicians to engage in the development of Physician-Focused
27 Payment Models by seeking guidance and refinement assistance from the Physician-
28 Focused Payment Model Technical Advisory Committee (PTAC). (New HOD Policy)
29
- 30 6. That our AMA continue to urge CMS to limit financial risk requirements to costs that
31 physicians participating in an APM have the ability to influence or control. (New HOD
32 Policy)
33
- 34 7. That our AMA continue to advocate for innovative ways of defining financial risk, such as
35 including start-up investments and ongoing costs of participation in the risk calculation that
36 would alleviate the financial barrier to physician participation in APMs. (New HOD
37 Policy)
38
- 39 8. That our AMA work with CMS, the Office of the National Coordinator for Health
40 Information Technology (ONC), PTAC, interested medical societies, and other
41 organizations to pursue the following to improve the availability and use of health
42 information technology (IT):
43 a. Continue to expand technical assistance;
44 b. Develop IT systems that support and streamline clinical participation;
45 c. Enable health IT to support bi-directional data exchange to provide physicians with
46 useful reports and analyses based on the data provided;
47 d. Identify methods to reduce the data collection burden; and
48 e. Begin implementing the 21st Century Cures Act. (Directive to Take Action)

- 1 9. That our AMA work with CMS, PTAC, interested medical societies, and other
2 organizations to design risk adjustment systems that:
 - 3 a. Identify new data sources to enable adequate analyses of clinical and non-clinical
4 factors that contribute to a patient's health and success of treatment, such as
5 disease stage and socio-demographic factors;
 - 6 b. Account for differences in patient needs, such as functional limitations, changes in
7 medical conditions compared to historical data, and ability to access health care
8 services; and
 - 9 c. Explore an approach in which the physician managing a patient's care can
10 contribute additional information, such as disease severity, that may not be
11 available in existing risk adjustment methods to more accurately determine the
12 appropriate risk stratification. (Directive to Take Action)
- 13
14 10. That our AMA work with CMS, PTAC, interested medical societies, and other
15 organizations to improve attribution methods through the following actions:
 - 16 a. Develop methods to assign the costs of care among physicians in proportion to the
17 amount of care they provided and/or controlled within the episode;
 - 18 b. Distinguish between services ordered by a physician and those delivered by a
19 physician;
 - 20 c. Develop methods to ensure a physician is not attributed costs they cannot control
21 or costs for patients no longer in their care;
 - 22 d. Explore implementing a voluntary approach wherein the physician and patient
23 agree that the physician will be responsible for managing the care of a particular
24 condition, potentially even having a contract that articulates the patient's and
25 physician's responsibility for managing the condition; and
 - 26 e. Provide physicians with lists of attributed patients to improve care coordination.
27 (Directive to Take Action)
- 28
29 11. That our AMA work with CMS, PTAC, interested medical societies, and other
30 organizations to improve performance target setting through the following actions:
 - 31 a. Analyze and disseminate data on how much is currently being spent on a given
32 condition, how much of that spending is potentially avoidable through an APM,
33 and the potential impact of an APM on costs and spending;
 - 34 b. Account for costs that are not currently billable but that cost the practice to
35 provide; and
 - 36 c. Account for lost revenue for providing fewer or less expensive services. (Directive
37 to Take Action)

Fiscal Note: \$5,000.

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⁴ Physician-Focused Payment Model Technical Advisory Committee (PTAC) Website. Available at <https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee>

⁵ 2016 AMA Physician Benchmark Survey.

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⁸ Peter Nichol, The Next Generation of Health IT. CIO. Available at <http://www.cio.com/article/3148800/healthcare/21st-century-cures-act-and-the-impact-to-healthcare-interoperability.html>

⁹ Harold Miller. Improving Resource Use Measurement Under MACRA. Available at <http://www.chqpr.org/downloads/ImprovingResourceUseMeasurementUnderMACRA.pdf>

¹⁰ *Id.*

¹¹ *Id.*

¹² *Supra* note 4.