

## Frequently Asked Questions (FAQs)

Additional Policy Issues of Interest for Leadership Day 2016

May 3-4, 2016

### MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT (MACRA)

**1. What is the status of the MACRA legislation that was enacted into law in April of 2015? What is ACP doing to help members prepare for the law's changes?**

MACRA was enacted into law last year repealing the flawed Medicare Sustainable Growth Rate physician payment formula and replacing it with a new payment system that creates opportunities for physicians to better serve patients by providing high value, coordinated, and patient centered care. In this new system physicians can choose to deliver care for their patients through Alternative Payment Models such as Patient Centered Medical Homes (PCMH's) or through a new Merit-Based Incentive Payment System (MIPS) that aligns care with value through incentives within the existing Medicare fee-for-service system. ACP endorsed MACRA and was a major stakeholder in its development.

ACP very much wants to ensure that MACRA is implemented successfully and according to congressional intent. ACP has been providing feedback on MACRA to the Centers for Medicare and Medicaid Services (CMS), the agency responsible for implementing the new law, mainly through Requests for Information that have come from the agency. CMS released its proposed rule on the new law on April 27. View ACP's initial reaction [here](#). Following a thorough analysis of the proposed rule, ACP will then provide formal comments to CMS.

ACP has created numerous resources to educate its physicians about MACRA and how to prepare for changes under the new law, including designing a new website (<https://www.acponline.org/practice-resources/business-resources/payment/medicare/macra>) specifically for that purpose. These resources are intended to assist physicians in preparing for changes that are to come under the new law and to help them transition from a volume-based payment system towards one that rewards value. Resources include: Easy-to-understand Frequently-Asked-Questions (FAQs) on the basics of the new law, guidance materials to help physicians transition their practices to the new payment systems (e.g. *ACP Practice Advisor*®), implementation resources, and what ACP is doing on the advocacy front with respect to MACRA.

**2. Is Congress involved at this point in MACRA now that it is in the implementation phase?**

Yes, the House Energy & Commerce Committee held a hearing on MACRA's implementation on April 19<sup>th</sup> where physician stakeholders were invited to testify. The committee is interested in exercising its oversight authority so as to ensure that MACRA is implemented successfully and according to congressional intent. ACP was honored with a request by the committee to testify, not only to provide its perspective on the new law but also to describe the steps it is taking to educate and prepare its members for MACRA's changes. See ACP's [release](#) and [testimony](#).

The committee has stated that this is but one hearing in a series of many hearings that it intends to hold on MACRA in order to highlight its many important payment and delivery system reforms and how stakeholders are preparing for the changes.

**3. How will MACRA impact the process for physicians reporting quality measures beginning in 2017?**

A major component of how much physicians will be paid under MACRA will be based on the quality of care that they provide to their patients. Since the quality measures that physicians will report on in 2017 have not been

set, this uncertainty leaves a looming question of how performance measures should be developed so that they protect, support, and provide useful information and feedback to both physicians and patients.

On March 1<sup>st</sup>, ACP sent a [letter](#) to CMS that outlined our concerns with the process for reporting quality measures under the new MACRA law. ACP believes that CMS should not consider adopting the existing quality measure sets within the Physician Quality Reporting System, Value Based Modifier, and Meaningful Use systems as starting points for its measure development plan. We believe that CMS should adopt 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, ACP stresses that 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, patient- and family- centeredness measures, care coordination measures, and measures of population health and prevention; and do not create unintended adverse consequences.

## HEALTH INFORMATION TECHNOLOGY

### 4. What is ACP's position on Interoperability?

ACP strongly supports the improvement of interoperability between clinical IT systems with the requirement that physicians be able to use the information. ACP supports in principle efforts to harmonize the definitions of common clinical data elements. However, ACP does have concern that the effort to increase interoperability could lead to a massive and cumbersome set of elements that will create a new and unacceptable burden on developers to implement and on physicians and other clinicians to collect and manage. In addition, ACP believes that what may appear to be appropriate to harmonize may change over time. The College recommends that requirements on health IT should avoid being overly prescriptive, and also be able to change based on discovery and evidence.

Therefore, ACP recommends that any initial set of common data elements be limited to just those elements deemed absolutely necessary for care delivery by physicians and other treating clinicians. Stakeholders should be required to spend a significant period of time attempting to use these clinical common data element sets before other elements are added.

ACP [recommends](#) that there be consideration of the inclusion of five information areas—rather than a minimum data set—that should be conveyed in all communications: 1) Current Problem List; 2) Current Medications; 3) Current Allergies 4) Clinical Note; 5) Contact information for all participants in the patient's care. The ownership and management of these data is most critical. Establishing some rules of etiquette and standard approaches for the handling of these data, based on best practices, would be a more meaningful and long term approach.

### 5. What's ACP's view of clinical documentation within EHRs?

ACP supports establishing a process that requires the Centers for Medicare and Medicaid Services (CMS) and other relevant federal agencies to reform or replace the existing E/M documentation guidelines with input from practicing clinicians and in collaboration with their professional organizations. ACP supports efforts to address the burden of clinical documentation requirements. ACP believes that the purpose and content of clinical documentation should return to supporting excellence in patient care. In a recent position [paper](#), ACP offered a number of solutions to clinical documentation that should be considered.

As reported out of the Senate Health, Education, Labor, and Pensions (HELP) Committee on February 9, 2016, the Improving Health Information Technology Act, S. 2511, contains a provision to reduce burdens for physicians. The provision does require that the Department of Health and Human Services (HHS) consult with providers of health services and health professional societies (Sec. 2, p. 2 or p. 53) in order to develop a strategy to reduce regulatory or administrative burdens, such as documentation requirements, including activities related to reporting clinical data for administrative purposes. (Sec. 2, p. 4 or p. 54) The bill would also specifically require recommendations for actions that improve the clinical documentation experience and improve patient care. (Sec. 2, p. 4 or p. 54) The HHS is required to develop the strategy and recommendations within one year of enactment. (Sec. 2, p. 3 or p. 53) ACP expressed support for this provision in its February 2, 2016, [letter](#) to the Senate HELP Committee regarding its January 20, 2016 discussion draft.

## **6. What is the proposed star rating system for EHRs within the HIT Act and what is ACP's position on it?**

Legislation is pending in the Senate that would establish a star rating system for certified health information technology. This legislation exists as a stand-alone bill introduced by Sen. Bill Cassidy (R-LA) called the Trust IT Act (S.2141). It is also included in a larger more comprehensive HIT bill, the Improving HIT Act (S. 2511), that is part of the Senate HELP Committee's efforts to advance Innovations legislation, as a counterpart to the House Energy & Commerce Committee's 21<sup>st</sup> Century Cures legislation.

ACP greatly appreciates Sen. Cassidy and the HELP Committee's intent to assist physicians and practices in choosing the right HIT/EHR system that meets their needs. The College however has concerns that this rating system may not provide sufficient detail and context to physicians and practices in evaluating options for adding or changing health IT components. ACP has expressed these concerns to both the HELP Committee and Sen. Cassidy's staff.

There are two key issues that practices have to struggle with in selecting an EHR system:

### *Having Enough Detail to make an informed decision*

One issue is that there is not one EHR system that is best for all practice situations. Each EHR is built around specific clinical workflows, and workflows vary significantly among practices. Oftentimes practices try to re-design their workflows to match the models used by a particular EHR, and they often fail disastrously because the EHR system's workflows do not match the real-life workflows of the practice.

So while an EHR system may achieve a high star rating—it could still yet perform poorly on a particular function that a practice considers critical. For example, a high scoring EHR system could be a completely wrong choice for any given practice, while a lower scoring EHR might actually be a far better fit.

Physicians and practices need detailed comments—from actual users of each system—in order to adequately determine the value of a system or component for their particular uses. Practices will need the full details of all of the evaluations that go into the ratings in a form that allows them to filter the results to match their specialty, size of practice, and other criteria. The evaluation of an internist is not very relevant to a surgeon.

### *More than just software—it's the full user experience*

Besides the software, an EHR system also includes training, support, customization, integration of components, support for billing functions, and availability of specific add-on functions.

Every practice will rate the importance of each of these and many other categories differently. Practices need an online evaluation service or tool that consists of many detailed ratings of EHRs in all of these categories so that they can determine as a group which aspects matter most, and which products are better in the areas that matter most.

For physicians and practices attempting to implement health IT, the smallest detail of another's experience can be crucial in determining whether a particular component will be a good fit and a star rating may not convey enough context for practical guidance.

*Is there an alternative?*

MACRA already calls for a technology comparison system. As an alternative to the proposed star rating system, the ACP believes a more workable and usable approach would be to utilize such a technology comparison system.

For example, the ACP, in collaboration with 18 other medical societies, has already developed AmericanEHR Partners (<http://www.americanehr.com/Home.aspx>) which currently meets the comparison-system requirements identified by MACRA and provides physicians and practices with the comprehensive range of information and tools needed to thoroughly evaluate health IT options.

## FEDERAL APPROPRIATIONS

### 7. What is the status of fiscal year 2017 spending bills in Congress?

The federal budget and appropriations process is now underway for fiscal year 2017, and it is up to Congress to decide funding for all federal programs, including those in health care. This coming fiscal year could prove to be challenging for primary care and physician workforce programs because the overall spending cap for nondefense funding (a.k.a. discretionary funding that Congress must approve annually) is essentially the same as last fiscal year.

There are several key federal health-related programs and activities that ACP has made its priority for fiscal year 2017. These programs are critical to helping to support a sufficient supply of primary care physicians and physician specialties facing shortages. The Health Resources and Services Administration (HRSA) is responsible for improving access to health-care services for people who are uninsured, isolated or medically vulnerable; the Title VII Health Professions program is the only source of federal training dollars available for general internal medicine, general pediatrics, and family medicine; the National Health Service Corps (NHSC) provides scholarships and loan forgiveness to primary care physicians and certain other clinicians in exchange for service in an underserved area; and the Agency for Healthcare Quality and Research (AHRQ) provides evidence-based information needed by consumers, clinicians, health plans, purchasers, and policymakers to make informed health care decisions. These programs are largely dependent on federal funding through the annual congressional appropriations process. It is therefore important for members of Congress to understand the merits of each program/initiative.

It is vital that sufficient federal funds continue to flow to these programs in fiscal year 2017. Therefore Congress should act to pass legislation to ensure that these programs are not only adequately funded, but do not have any interruptions in their funding.

Read ACP's written statement about FY2017 health-care program funding to the [House](#) and [Senate](#) Appropriations Subcommittees.

## INNOVATIONS LEGISLATION

### 8. Both the House and Senate are working on "Innovations" legislation but what does that mean exactly? What is ACP's position on such legislation?

In July 2015, the House passed the 21<sup>st</sup> Century Cures Act (H.R. 6), which was comprehensive legislation borne out of the Energy and Commerce Committee. H.R. 6 addresses a myriad of innovation reforms from funding for

the National Institutes of Health to combat diseases, to efforts to spur development of new drugs, vaccines, and devices, to improving health information technology. ACP did not take a position on H.R. 6 as a whole largely because we do have policy on many of its provisions. While the House passed H.R. 6 in a bipartisan fashion, the Senate chose not to take up that legislation but rather to develop its own companion “innovations” legislation that is currently under development by the Senate HELP Committee.

The HELP Committee is moving at a more deliberate pace on its companion innovations legislation, which currently exists only as individual topical bills that we anticipate will eventually be joined into one comprehensive bill. The HELP Committee has already held three markups of several separate pieces of legislation:

- The first markup on February 9, 2016, was on seven bipartisan bills, including, S. 2511, the Improving Health Information Technology Act, which were all voted favorably out of the HELP Committee. See ACP’s [letter](#) regarding the January 20, 2016, discussion draft of the Improving HIT Act.
- The second markup took place on March 9, 2016, and was focused on modernizing the Food and Drug Administration (FDA) and its drug and device approval process. On that date, seven bipartisan bills were approved by the Committee.
- The third and last markup on April 6, 2016, focused on the National Institutes of Health (NIH) and bringing reform to how NIH conducts research. On that date, five bipartisan bills were approved by the Committee. ACP did not provide formal feedback to the committee on the other individual pieces of legislation, other than on the Improving HIT Act.

While ACP anticipates that all of these committee-approved bills will be combined into one large “innovations” bill, there is a stumbling block on the issue of funding. Both Republicans and Democrats agree that there should be additional funding for biomedical research for NIH. There is some disagreement about where that funding should come from. Democrats on the HELP Committee insist that the additional NIH funding should be newly created “mandatory” funds—funding that does not go through the annual appropriations process and would not be subject to the overall spending caps that apply to discretionary spending, which is funding that is appropriated annually. Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA), as well as Senate leadership, are trying to negotiate an agreement to move forward. Any new mandatory funds would have to be offset by less spending or increased revenue elsewhere in the federal government.

## TELEMEDICINE

### 9. Describe legislation under development in the House that addresses bundled payments and telemedicine.

The House Energy and Commerce Committee has created a Telehealth Working Group (TWG) that is meeting with stakeholders, including ACP, to discuss and get feedback on ideas about how to expand the use of telemedicine in Medicare. The TWG is in the early stages of formulating an approach that could include a voluntary option for physicians and beneficiaries under Medicare to access telehealth services without the existing current-law limitations. An approach under consideration could include a bundled payment for certain primary care services delivered via telemedicine or face to face. This approach would be a voluntary option for both patient and physician. ACP provided informal feedback to the TWG indicating our support for the intent of the discussion draft but also had many questions for the TWG as to the scope and direction of the draft.

ACP has shared its telemedicine position [paper](#) with the TWG and has explained to the TWG that ACP supports the expanded role of telemedicine as a method of health care delivery that may enhance patient–physician collaborations, improve health outcomes, increase access to care and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care. The College also conveyed

to the TWG that it supports the expanded role of telemedicine and believes that it can be most efficient and beneficial when provided as part of an established, ongoing relationship between a patient and physician. The College also strongly recommended to the TWG that telemedicine be held to the same standards as if the physician were seeing the patient in person. Finally, ACP shared with the TWG that it supports reimbursement for appropriately structured telemedicine communications, both synchronous and asynchronous, as well as a variety of forms of communication (e.g., text-based, voice, video, or device feeds) that are determined to be clinically appropriate.

## **OPIOID ABUSE LEGISLATION**

### **10. Explain how both chambers are trying to address the growing problem of opioid and substance abuse disorders.**

In March, the Senate passed legislation, the Comprehensive Addiction and Recovery Act of 2016 (CARA/S. 524) in an effort to address the growing problem of substance abuse disorders. It passed with an overwhelming majority of 94 to 1. View ACP's letter of support [here](#).

Similarly, the House has chosen to develop its own version of the Senate-passed CARA legislation. The House version currently exists as separate bills, 12 of which are undergoing consideration by the Energy and Commerce Committee and 5 others, which are undergoing consideration by the Judiciary Committee and the Education and Workforce Committee. All measures are expected to be approved by the committees during the week of April 25<sup>th</sup>. We anticipate that the House leadership may combine the separate bills into one comprehensive package for floor consideration in the middle of May. The goal would then be to reconcile differences between the House bill and the Senate-passed CARA legislation and pass a single bill through both chambers in time for the President to sign it before the summer recess period.

The House bills include: measures expanding patient access to medication-assisted treatment and allowing partial fillings of opioid prescriptions; increasing access to the overdose reversal drug naloxone and expanding services for pregnant women or mothers with young children battling substance abuse; requiring the FDA to consult outside advisers before changing labels on opioids, developing education programs for opioid prescribers, and creating an inter-agency task force to update best practices for pain medication prescribing, among other things.

ACP has not taken a formal position on each of these separate House bills at this juncture but is largely supportive of their intent. ACP will provide feedback to the House when a comprehensive package is unveiled.