



**Statement for the Record**  
**American College of Physicians**  
**Hearing before the Energy and Commerce Health Subcommittee**  
**On**  
**MACRA and Alternative Payment Models: Developing Options for Value-based Care**  
**November 8, 2017**

My name is Louis Friedman. I represent the American College of Physicians (ACP), the nation's largest medical specialty organization, representing 152,000 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 board certified in internal medicine and am a Fellow in the American College of Physicians. Since 2001, I have been in private practice at Woodbridge Medical Associates, Woodbridge, New Jersey, which has been NCQA-certified as a patient centered medical home, level 3, since 2008. My practice participated in the Comprehensive Primary Care Initiative (CPCi) for three years and is now enrolled in the Comprehensive Primary Care Plus (CPC+) program, track two.

On behalf of the College, I would like to express our appreciation to Chairman Burgess and Ranking Member Green for convening this hearing and for allowing those of us on the front lines of patient care to share our experiences in the transition to value-based care, not only through existing Alternative Payment Models (APMs) but through new ones as well. Thank you for your shared efforts in wanting to ensure that these models improve health outcomes while reducing costs, as intended under the Medicare Access and CHIP Reauthorization Act (MACRA).

Today, I am pleased to have this opportunity to share ACP's perspective on MACRA and its ongoing implementation, specifically with respect to Alternative Payment Models (APMs), including their

impact on ACP member physicians, but also my own practice experiences in having worked within the Comprehensive Primary Care Plus (CPC+) program.

## **OVERVIEW OF ACP's VIEWS ON 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 Medicare's Sustainable Growth Rate (SGR) formula, to one of value, accountability, and patient-centered care. ACP has been active in providing feedback on the implementation of the Quality Payment Program (QPP) as established by MACRA via its letters on both the [2017](#) and [2018](#) proposed rules, as well as on the [Measure Development Plan](#) and other requests for information and feedback from the Agency.

Repeal of the SGR was a priority of ACP's, and nearly all of medicine, for more than a decade. Thanks to the passage of MACRA, physicians and their patients no longer have to be concerned with impending yearly payment cuts as a result of the flawed SGR formula. However, as noted earlier, MACRA not only repealed the SGR, it also has led to a true shift in the Medicare program from a volume-based payment and delivery system to one of value, accountability, and patient-centered care—an approach the College strongly embraces. In a recent [paper](#) outlining its forward-looking priorities, ACP recognizes the importance of MACRA in helping to ignite movement by Medicare toward these aims, and then calls for even further acceleration of the transition from fee-for-service (FFS) payment systems to bundled and risk-adjusted capitation payments, hybrid FFS + bundled/capitated payments, and other payment systems that incentivize value rather than volume.

### **Alternative Payment Models (APMs) and Advanced APMs**

To achieve this acceleration, ACP believes that all public and private payers should transition their payment systems to support innovative payment and delivery models linked to the value of the care provided. This should be accomplished by testing a variety of APMs, such as accountable care organizations (ACOs), Patient-Centered Medical Home (PCMH) and Patient-Centered Specialty Practice

models, bundled payments, capitated payments, and others. These models should include risk adjustments, including adjustments for socioeconomic status, to the extent possible. The College also has recommended that the Centers for Medicare and Medicaid Services (CMS) work to ensure patients, families, and the relationship of patients and families with their physicians are at the forefront of the Agency's thinking in the implementation of APMs and the advanced APM pathway within the QPP, including as part of the development and implementation of the performance measures to be used within these models.

In recognition that all clinicians are not willing or able to move directly into models with significant payment at risk, there should be pathways to help clinicians transition to models with increasing levels of risk at stake. ACP particularly believes that the PCMH model has been shown to improve quality and patient and physician satisfaction, reduce health care disparities, and reduce costs—and therefore has repeatedly recommended that CMS provide multiple pathways for medical homes to be included in the advanced APM pathway within the QPP, even in some cases without bearing more than nominal financial risk (particularly if it is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c)).

The College further believes that APM development and implementation for clinicians who currently lack opportunities—such as specialists/subspecialists; clinicians who are unable to participate in current models, such as those in regions where models are not being tested; and those who are unable to participate due to limitations in the model design—should be prioritized. In particular, this should include testing of the patient-centered specialty practice model as a potential Advanced APM.

### **Importance of the CMMI and PTAC**

The College strongly supports the Center for Medicare and Medicaid Innovation (CMMI) and its essential role in developing, financing, implementing, evaluating, and expanding innovative physician-led Advanced APMs, as authorized by MACRA, as well as in the broader context of value-based payment and delivery system reform. Along these lines, ACP has encouraged CMS to fully use its authority under the CMMI and the Physician-Focused Payment Model Technical Advisory Committee

(PTAC) process to expand the availability of Advanced APMs and other models, as noted earlier. In order to accelerate the movement toward value-based payments, ACP believes there should be an expedited process for CMMI to develop, test, and expand APMs. This should include a clear pathway for testing models recommended by PTAC, as well as models from other payers including Medicaid and private payers. The creation of additional APMs would provide more opportunities for practices to transition from traditional FFS to more valued-oriented payment approaches. It is also imperative that the CMMI continues to have adequate funding to support its critical role in MACRA/QPP and the movement toward value-based payment. Further, the College looks forward to providing robust feedback to the CMMI per its recent “New Direction” Request for Information (RFI).

ACP also believes that CMS should make technical assistance available to stakeholders who are developing APMs for PTAC review. Organizations that seek to propose models through the PTAC often lack sufficient expertise in at least a few areas that are needed to fully develop proposals for review, causing changes to be made throughout the PTAC process. The CMMI could provide this technical assistance to organizations as needed throughout the development process based on expertise gained in the design and testing of other models. This would not only enable the stakeholders to submit a proposal to the PTAC that is more comprehensive, but also allow the PTAC to conduct a more thorough review and recommendation to CMS. It also could make it easier for the CMMI to take steps to test models recommended by the PTAC if the CMMI aided in development of components that are required for implementation.

### **ACP Views on the Comprehensive Primary Care Initiative (CPCi) and the Comprehensive Primary Care Plus (CPC+) Programs**

The College was a strong supporter of the CPCi program and remains supportive of and encouraged by the ongoing CPC+ program, the only medical home model that is specifically identified as an advanced APM in the QPP (for those in practices with 50 or fewer clinicians). ACP believes that CPC+ offers the potential of greatly strengthening the ability of internists and other primary care clinicians, in thousands of practices nationwide, to deliver high value, high performing, effective, and accessible primary care to millions of their patients. The success of this program will 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 ongoing implementation of this program to ensure that it is truly able to meet such requirements of success.

It is with this in mind, that I share my perspective as an internal medicine physician practicing in a participating CPC+—and former CPCi—practice.

### **PERSPECTIVES OF A PARTICIPATING CPC+/ADVANCED APM PRACTICE**

In the three years since our practice started participating in the CPC initiative and now, one year into the CPC+ program, track 2, we have gained significant knowledge of the benefits and challenges of the program.

#### **Benefits of the CPC+ Program**

The addition of care coordination staff has enabled us to better track our patients who have been discharged from the hospital, reach out to them within 48 hours of discharge, and review medications and determine whether further ancillary services are needed. Follow up visits are also arranged at that time, which has helped to limit confusion on the patient's part and we anticipate this will lead to a decrease in readmissions.

We have expanded our ability to analyze and deliver care and our patients have benefitted in many ways. With the added financial support that the CPC+ program provides, we have been able to offer self-management programs such as nutrition classes and dietitian visits. These are available free of charge to patients, and have been well received by many who need them. Gaining a patient's commitment to attend these classes on a regular basis, however, can be inconsistent. That being said, I had one patient who was six foot three inches tall and weighed 442 pounds. He had high blood pressure and terrible venous insufficiency of the legs which causes massive chronic swelling. He enrolled in our eight week class and by the end of it had lost 31 pounds. He dropped another 10

pounds in the next two months and his swelling improved. This is an extreme example, but shows that we can induce positive lifestyle changes which in turn can help prevent disease.

Feedback data from CMS is another tool that we did not have access to previously, but now do as a result of our participation in CPC+. Often patients simply are not aware that many medical issues such as upper respiratory infections, rashes and minor cuts and bruises can be easily treated in a less expensive urgent care or office setting (often with a shorter wait for the patient). Now we can review the number of our patients per quarter who were admitted to the hospital, seen in the emergency room or seen in urgent care centers. Once identified, we hope to better educate these patients as to when and when not to seek emergency room care. Prior to CPC+, we did not have this ability and thus had no idea how many unnecessary emergency room visits there were.

Pre-visit planning by ancillary staff and effective monitoring within the EHR have helped us to improve our rates of vaccination, screening procedures for mammograms, and diabetic eye exams. Screening tools for early detection of dementia have helped at-risk families better prepare to care for their loved ones. The CPC+ reimbursement for managing patients with this diagnosis has been helpful with targeting this effort.

On a practice management level, regulations issued by CMS and the Office of the National Coordinator (ONC) requiring EHR vendors to obtain health information technology certification, as part of the EHR Incentive Programs, has made it possible to track patient parameters more effectively. Bear in mind that there are many EHR vendors out there, large and small, and many of them simply had not been powerful or sophisticated enough for a practice to track and report the measures required by the program. Prior to enactment of these regulations, EHR vendors had no incentive to create effective dashboards with which we can track patient measures (blood pressure, blood sugar measurements, screenings such as mammograms and eye exams). Without this ability, there would be no way that a practice could hope to report the necessary measures for the program.

### **Challenges of the CPC+ Program**

While my experience overall with CPC+ has largely been positive, we have noted challenges with the program as well. There is an administrative component to CPC+ that cannot be overlooked, which

necessitates having a strong administrative team in place to truly allow the physicians to concentrate on clinical practice. Physicians are trained and motivated to take care of patients, and are not naturally inclined to deal with software problems and other administrative tasks. Our practice structure is organized so that doctors' hours are focused on addressing clinical issues, although we routinely review performance measures at practice meetings. While the physicians are seeing patients, a multitude of other activities occur related to the CPC+ and other quality improvement programs. These include team meetings with our medical assistants, front desk and care coordination staff, as well as communication with our EHR vendor to determine how best to help the practice track and meet the milestones. This all requires careful choreography so that high risk and recently discharged patients are contacted in a timely fashion, appointments are arranged and assessments are made the day before a visit so that nothing is missed during the visit. All this happens in the background of a medical office where the more typical activities such as patient check-in, insurance issues are resolved, medical assistants and physicians are evaluating patients and in-office procedures are done as needed. We are fortunate to have effective administrative talent in our office to handle these tasks, however many practices of our size or smaller lack the resources and the ability to attract the needed staff. Employing a full-time trained accountant and/or project manager who can design a budget and analyze the constant flow of data is not feasible for most small practices, but there is a need for that in a CPC+ practice. Many physicians have needed to outsource these tasks, thus adding to overhead.

In addition, computer software, hardware and information technology support are fundamental for any practice hoping to excel in CPC+. Once again, keeping our EHR and related hardware up to date and running smoothly requires appropriate staff and constant communication with a software vendor, who is also a CPC+ stakeholder.

Office staff requirements have changed overall as a result of our participation in CPC+. As previously mentioned, administrative staff needs to have experience in accounting, project management and computer hardware, unless these are outsourced, in order to meet the demands of a CPC+ practice. We also have found a need for specialized staff who have knowledge and understanding of a given health care demographic or population. For example, population care coordinators are now needed in our practice, which is a new position that we, as well as other practices, have had difficulty finding and

retaining. Furthermore, meeting the demands of this type of practice also requires someone with a clinical background, extensive telephone communication skills, and the ability to analyze spreadsheets of patient information. These care coordinators can help follow through on the physician's treatment plan to make sure it happens. Coordinators can make sure patients get the procedure they need scheduled, the medications they need covered and filled and filter out those that are no longer needed. They can help direct patients to behavioral health centers, home health agencies and rehabilitation programs and work to ensure the implementation of their care plan. The ideal candidate would be a nurse, yet most nurses prefer face-to-face clinical contact. I believe this job description is evolving and, for our practice, currently requires the work of multiple employees.

### **Future Options for Improvement under the CPC+ Program**

I would be remiss if I did not acknowledge that there is a financial incentive to participation. However, this is needed for the practice to maintain the appropriate staff and computer systems. An increased financial incentive would make the program more attractive to prospective practices as well as provide the financial resource to improve their infrastructure.

Overall, I believe that our patient care has improved since participating in this program. With that, I would like to offer to this committee and to Congress ideas for improvement to the program. Looking to the future, there is a need to simplify the reporting requirements under CPC+. As more private payers enter the APM market, one option would be to streamline specific metrics across both CMS and the private payer models. Reporting measures should be realistically achievable with the understanding that the physician can guide patients but ultimately, parameters such as BMI, blood pressure and blood sugar control are as much about patient engagement as they are about the expertise of the clinician. In addition, efforts should be made to encourage interoperability among EHR software vendors. This would lead to better electronic communication between medical offices and hospitals.

### **The Need to Stay the Course and Move Away from a Fee-for-Service System**

As I reflect on the changes that have occurred in the practice of medicine, payment for medical care has changed a great deal since my father started his general practice in the early 1960s. At that time,



care was reactive in practice rather than the proactive approach that has become the current standard. Among the vast differences, chronic diseases such as diabetes and high blood pressure were not as prevalent, and preventive care was not recognized as a priority. A simple fee-for-service model worked well then, but simply is not as effective in addressing chronic disease management. We must continue to move forward with value-based, coordinated care, such as can be found in programs like CPC+, the medical home, and other APMs, and away from the fee-for-service system. Given the time and effort our practice has invested over the past few years toward this end, as well the significant and incremental improvements we have experienced, we plan to continue with this model and not return to a purely fee-for-service structure.

#### **VIEWS FROM THE BROADER ACP MEMBERSHIP ON MACRA, APMs, and CPC+**

As noted earlier, ACP's membership is made up of 152,000 internal medicine physicians, related subspecialists, and medical students—just over half of its post-training members identify themselves as primary care physicians. ACP members who provide care directly to patients are in a variety of different practice sizes and settings, ranging from small independent practices to being employed within large health systems. A recent survey of a random sample of ACP members indicates that, since 2016, practice participation in advanced payment and delivery models is increasing—and a large percentage of the respondents noted that they are making changes to prepare for successful participation in the QPP overall. Beyond these survey data, however, the feedback coming from ACP members through their chapters and up to ACP National is that they want to participate in APMs and are eager to have more opportunities available in their area and/or that are relevant for their specialty.

ACP members who are primary care internists are hearing from their colleagues like me about the improved bottom line from having been in CPCi and now CPC+ participating practices, and more importantly, about the changes we have been able to make in terms of infrastructure, staffing, and technology to truly improve patient care. And they want in! At a recent meeting of one of ACP's policy committees, a member stated that she simply cannot figure out how to sustain her rural, primary care practice on fee-for-service alone—"It's killing me," she said. And the impact of fee-for-service alone on an internist's practice goes beyond ensuring they keep their doors open in order to maintain an accessible source of care, to impacting their ability to provide the high quality and patient-centered

care they would like to provide to their patients. This is why the drumbeat of interest is growing, particularly since the passage of MACRA.

Another factor driving the interest of ACP members in pursuing alternative payment models is the excessive administrative burden they face, particularly within a strictly fee-for-service environment. This is why ACP launched its [“Patients Before Paperwork”](#) initiative in 2015 in order to develop and maintain related policy, participate in various efforts to work to alleviate specific regulatory and insurance requirements, and identify opportunities to eliminate other unessential tasks that detract from patient care and contribute to physician “burn-out.” Ideas for how to address excessive administrative tasks are outlined in detail within its policy paper [“Putting Patients First by Reducing Administrative Tasks in Health Care,”](#) which was published in the *Annals of Internal Medicine* in March 2017 and was recently [supported by the American College of Obstetricians and Gynecologists](#). Therefore, ACP is pleased with the new initiatives recently announced by CMS to put “Patients Over Paperwork” and to ensure that the agency is using “Meaningful Measures” in all of its programs, including the Quality Payment Program—and have [offered](#) to actively engage with the Administration to address these issues.

Interest in APMs is not limited to primary care internists and to current models like CPC+, but is also shared by ACP’s internal medicine subspecialist members. This is why the College is such a strong advocate for testing and implementing models built around the patient-centered specialty practice approach, as initially outlined in its [“Patient-Centered Medical Home Neighbor”](#) paper in 2010. ACP members regularly reach out for any information or assistance the College can provide to help them to help prepare for participation in APMs or even to develop new ideas for subspecialty-relevant APMs, noting the importance that these models be able to interact successfully with the PCMH/CPC+ model, as well as other models being implemented now, in order to ensure true population health management and care coordination.

## CONCLUSION

The College would again like to sincerely thank Chairman Burgess and Ranking Member Green for convening this hearing and for your continued desire to see that the value-based system, as established under MACRA, is successfully implemented. We in the physician community appreciate this opportunity to offer our input on how these models are impacting our practices and patient care, both now and throughout the transition. We very much want to be part of this process and to provide feedback whenever needed.