Subject: MACRA

October 20, 2015
Robert Shor, MD, FACC (rshor@tcg.md)

To ALL:

MACRA presents a degree of uncertainty in our future not seen in some time. The talk at the Leg meeting was enlightening and confusing and for me, a bit scary as well. Much of the details have yet to be flushed out. While we wait for the slides from the talk to be sent out (and eventually placed in to our new portal) I have attached slides prepared by our Advocacy team from July.

October 20, 2015
John Erwin, MD, FACC (jperwin@sw.org)

Thank you, Bob. I thought it was just me. Wonderful job on BOG & Leg Session. Thank you for your sage leadership.

October 20, 2015
Matthew Phillips, MD, FACC (mattphillips1@me.com)

Excellent meeting

We met with legislators that were all supportive

They seem to understand

1. The EHR turned us into typists they all have witnessed as patients
2. Is scaring patients with the clinical summary as an example of regulations not making sense
3. Do everything but talk to each other
4. Agree that we (ACC) and not CMS needs to figure out what the quality metrics are and how many or chaos will ensue
5. Support research
6. Support cardiac rehab changes
7. Understand Stark is outdated
8. In general hope to get health care back to the providers

Good to see everyone-

October 20, 2015
Edward Tuohy, MD, FACC (et@cardiacspecialists.com)

Bob-

Great meeting with, I agree, lots of scary. It is clear the direction HHS wants to take MACRA and I (and I'm sure many others) fear we have no idea how to get paid in what seems like only a few years. Fortunately, it seems, neither does HHS. This, while scary, presents a great opportunity for us to have an impact on shaping our future. I returned today and also attended our CAC (Carrier Advisory Council) meeting for NGS Medicare. While the material presented had nothing to do with cardiology, per

se, they rolled out several bundled payment projects. I would encourage every Governor to make sure they have organized presence on their local CAC. The medical director of ours feels that this is of the places where we can have direct input into the process of how we will be paid in the future. Unfortunately, for some specialties, there is no representation. But for ACC, we have robust national support and should not fail to utilize this avenue of monitoring/input, along with as many other ways we can try to influence the process.

We had a similar experience as Matt with our legislative assistants. They seem to get the fact that EHR's have the aforementioned issues, but lack a clue as to how to get them to do what is best for patients. At least they seemed to side with us. They also supported the increases in federal funding for medical research, but as Harlan Krumholz is tweeting, I suspect there will be more focus on the real ROI of any research projects or large clinical trials in the future.

It's a whole new world every meeting it seems…

October 20, 2015
Norman Lepor, MD, FACC (norman.lepor@gmail.com)

I agree Robert. I know there was tremendous relief with the resolution of SGR but based on my limited KNOWLEDGE of its replacement MACRA and the "devil is in the details" and the lack of faith I have in the powers that be in Washington just did not lead me to be so enthusiastic. All I can say about the concept of "change" is that sometimes it's good and sometimes bad. My wife also calls me a cynic :). So I guess that's just my nature

October 20, 2015
Timothy Dewhurst, MD, FACC (tewhurst@comcast.net)

I look at MACRA as a once in several generations chance to get it right. It is scary, but we also have almost a blank slate to create from. The way it is constructed, and with the CMS innovation center, we will have the flexibility to try several solutions.
We (ACC) are very well positioned to help this succeed. I share Ed's cautious optimism.

Our Leg meetings went well, having 2-3 ARNPs telling patient stories went over very well. As expected in WA state there was no push back on any of our talking points and our examples of EHR successes were appreciated and gave more credence to the plea for inter-operability.

Thanks to Bob, Matt and the ACC staff for a great meeting

October 21, 2015
David May, MD, PhD, FACC (dmay@cvscardio.com)

Good afternoon,

I trust everyone had uneventful travels home.

I have attached a rather sobering piece that I am sure many of you have read regarding the way we as physicians are viewed by the insurance industry. It is a rather unflattering expose of our naive approach to our business operations and the child-like ways in which our efforts are brushed aside.

Unfortunately, I believe that we are viewed in a similar fashion by hospital administrators, the Congress, and the virtually all the others with which we interface in the business realm.

Until we decide to engage in this type of endeavor on their terms, we can expect no better outcome, MACRA included.

Perhaps we should lay aside our "knives" for a more serious armament this go round?

http://www.medscape.com/viewarticle/852977

October 21, 2015
Edward Fry, MD, FACC (fry5@comcast.net)

Agree with all: Great BOG meeting and Leg. Conference. Impressions from the visits with Lawmakers:

- ACC is lucky to have a bunch of smart, dedicated, hard working staff, Chapter Exec's, FIT's, ECP's, engaged members and leaders. - We need everyone's talents now more than ever
- MACRA may well become the living example of "be careful what you wish for". Lawmakers are glad to accept our thanks for passing SGR repeal, but they themselves, like most clinicians, do not have a clue as to what is really in it and how it will work. Most said "Whew!, glad that's off my plate". MACRA and MIPS are ill-defined mechanisms to drive all providers and patients to even more ill-defined APM's. Translated: Medicare is to become a purely capitated delivery model. Importantly, our members must know there WILL be losers with MIPS, by design, to keep it budget neutral (actually budget negative when you factor in inflation even at the current low levels). This is needs to be contrasted with the current VBP "sticks", where penalties only occur if you fall below each of the various quality thresholds. In MIPS, it appears that you can still meet quality thresholds, but if 50% of your peers perform to a higher level, you could be penalized in the zero-sum game. This is a marked difference poorly understood by most.
- EHR Interoperability: All the legislators understood this to be the Achilles Heel of health IT, most through first hand experience at their own doctors offices and having heard from every corner of the house of Medicine, not just cardiology. They appreciate the need to create standards, transparency, and to hold the current EHR vendors' feet to the fire, but are reluctant to create a new bureaucracy or to be "anti-competitive", believing, incorrectly in my opinion, that market forces will prevail.
- Funding for Medical Research and GME: All support the 21st Century Cures Act - "motherhood is good", as long as motherhood does not cost too much. Most were unaware of the fact that >500 med school graduates could not find residency slots last year due to fewer positions, resulting from Medicare cut backs. We informed them that this problem would be like compound interest when coupled with the growing need for physicians and APP's. We helped them with the math of average age of cardiologists at 56, up to 2000 cardiologists per year retiring or slowing down soon (EHR's not helping), and that only 900 new fellows complete training per year. Lots of lip service but little commitment to make investments for the future. We brought this back to the "Access" part of the Triple Aim.
- Cardiac Rehab: We educated lawmakers about the reduction in MI and CHF readmissions as well as lower mortality with rehab, but were countered by the CBO scoring of $300 million for the legislation based on the fear that freeing up physicians to be off doing other (unnecessary?) costly things - Yes, that is really part of the calculation. This ties in directly with the buzz around the NYT story of abuse in Munster IN.
- Fraud and Abuse: They understand that it is infrequent but must live with the sensationalism that consumes their constituents. This was really not on our agenda, but we used the opportunity to

highlight the College's CPG's, AUC's, and Registries as tools to limit, or at least measure, such abuse. May be next year we can advocate for liability protections for individuals and hospitals to police themselves locally, perhaps as part of a bigger tort reform effort.

Overall, the focus was clearly on what is best for patients. Lawmakers truly appreciated the absence of a self-serving agenda.

October 21, 2015
John Ewin, MD, FACC (jperwin@sw.org)

Great summary, Ed. Our findings were similar to yours, but the Congressmen from Texas were still able to understand the greater cost savings from HB3355.

I just want to say that every time that I interact w our ACC leadership (you guys), I leave feeling energized no matter what our challenges!

Thank you all for your service!

October 21, 2015
Timothy Dewhurst, MD, FACC (tdewhurst@comcast.net)

Ed, as usual, well said.

I want to pick on one thing you mentioned "There will be losers".
This is the item I tried to get Dr. Krauthammer to bite on Sunday night.

In my opinion the losers should not, and do not need to come from the house of medicine. They should come from (in order of preference)
1). Insurance companies
2). Insurance companies
3). RBMS
4). Pharma
5). Imaging companies.
We need to make a very strong message that they add lots of cost and little value.
Insurance companies (and those who receive their political donations) will bleat about competition.
We need to bleat louder about the 20% of direct health care dollars they suck up and the 10-15% they cost us in billing and coding departments and lost productivity.

To paraphrase Churchill. "Single payer is the worst form of health care financing, except for all the others!"

Let's get over political firewalls and accept the reality of the economics and make sure the insurers lose, not the patients and providers.

October 21, 2015
Jesse Adams, MD, FACC (jdams03@bluegrass.net)

Great comments. I certainly want to repeat the thank stop Bob and all others who worked so hared for a fantastic meeting, and I hope everyone had a great trip home. It was wonderful to get to see all in DC. A few additional points:

1. Like others, there was interest in the cardiac rehab bill. We really did not have any push-back on the CBO score of 300 million. There was a widespread lack of respect for the CBO analysis. And when we met with Rand Paul, one of the more financially conservative of the senate Republican caucus, once he understood the "logic" that led to the CBO score he indicated that he wanted to study the bill but would certainly consider both supporting the bill and potentially being a co-sponsor.. And there was widespread "surprise" that we were supportive of this since it would allow APPs to do more.

2. We had a very nice, long, relaxed chat with Rep John Yarmuth. I have met him a number of times here in the district as well as in DC. He made a point that I had never fully considered- that the greatest problem with the SGR was that each year that was one of our major asks, and once that was delayed it significantly weakened our hand for any other substantive proposal or influence.

3. Stimulated by the meeting I was reading MACRA and MACRA analyses on the way home (going to sleep when I got home was a snap!). I did not realize that there was an EMR interoperability section in MACRA. That may well have been mentioned, but if so I missed it. I have posted a short section on this below (this is from the Congressional Research Service report, available at http://democrats.waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/CRS%20report%20on%20HR%202.pdf). The entire report is long but excellent, and here's the specific section that deals with EMR interoperability:

Section 106(c). Promoting Interoperability of Electronic Health Record Systems.
The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 amended Medicare (i.e., SSA Sections 1814(l)(3), 1848(o), 1853(l)&(m), and 1886(n)) and Medicaid (i.e., SSA Section 1903(a)(3)(F) & (t)) to authorize incentive payments to eligible hospitals and physicians—and certain other health care professionals—who attest to being "meaningful users" of certified electronic health record (EHR) technology. The HITECH Act defined meaningful use as using certified EHR technology in a meaningful manner (e.g., eprescribing), and using the technology to exchange electronic health information with another EHR system and to report clinical quality measures to the Secretary. The law also instructed the Secretary to make the measures of meaningful use more stringent over time, which CMS is doing in stages.

To meet the initial stage (i.e., Stage 1) of meaningful use, eligible hospitals and physicians must use their EHR technology to meet a series of objectives that generally involve capturing and storing structured patient data (e.g., vital signs, medications, lab test results). Providers must use EHR technology that has been certified by an accredited certification authority to perform these functions. Providers now in their third or fourth year of participation in the program are moving to meaningful use Stage 2, under which they must use their EHR technology to perform certain additional functions including some exchange of patient data during transitions of care (e.g., a hospital discharge to a rehabilitation facility, or a physician referral). The term EHR interoperability is used to refer to the ability of EHR systems not just to exchange electronic information but to be able to use the information based on common standards. While the Medicare and Medicaid incentive programs have had a significant impact on promoting the widespread adoption and use of EHR technology in hospitals and physician practices across the country, significant challenges remain in achieving widespread EHR interoperability.

This provision of H.R. 2 would declare it a national objective to achieve widespread interoperability of certified EHR technology by December 31, 2018. The Secretary would be required, in consultation with stakeholders, by July 1, 2016, to establish interoperability metrics to measure progress towards achieving that objective. If the objective were not met by December 31, 2018, then the Secretary would have until December 31, 2019, to submit a report to Congress identifying the barriers to widespread interoperability and providing recommendations for achieving the objective. Such recommendations may include (1) payment adjustments for not being meaningful EHR users under the Medicare EHR incentive program; and (2) the criteria for decertifying certified EHR technology products.

The Medicare EHR incentive program would be amended to require eligible hospitals and physicians, beginning one year after enactment, to indicate through meaningful use attestation (or some other process specified by the Secretary) that they had not knowingly and willfully taken any action to limit or restrict the interoperability of their certified EHR technology.

The Secretary would be required, within one year of enactment, to submit to Congress a report on ways to help providers compare and select certified EHR technology, such as through surveying EHR users and vendors and making such information publicly available.

October 21, 2015
John Erwin, MD, FACC (jperwin@sw.org)

Great EHR article by Lisa Rosenbaum:

http://www.nejm.org/doi/full/10.1056/NEJMp1509961?query=TOC#article

October 21, 2015
Jesse Adams, MD, FACC (jadams03@bluegrass.net)

Thanks John- hadn't read this yet. And of those that have not yet read it, the book by Wachter that he quotes is an interesting read- parts of which I agree with, parts not, but insightful nonetheless.