

**MEDICARE ACCESS AND CHIP
REAUTHORIZATION ACT OF 2015:
ENSURING SUCCESSFUL IMPLEMENTATION OF
PHYSICIAN PAYMENT REFORMS**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED FOURTEENTH CONGRESS
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CONTENTS

OPENING STATEMENTS

	Page
Hatch, Hon. Orrin G., a U.S. Senator from Utah, chairman, Committee on Finance	1
Wyden, Hon. Ron, a U.S. Senator from Oregon	3

ADMINISTRATION WITNESS

Slavitt, Andy, Acting Administrator, Centers for Medicare and Medicaid Services, Department of Health and Human Services, Baltimore, MD	5
---	---

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Hatch, Hon. Orrin G.:	
Opening statement	1
Prepared statement	25
Slavitt, Andy:	
Testimony	5
Prepared statement	26
Wyden, Hon. Ron:	
Opening statement	3
Prepared statement	32

COMMUNICATIONS

Alliance of Specialty Medicine	33
American College of Physicians (ACP)	37
American Congress of Obstetricians and Gynecologists (ACOG)	44
American Hospital Association (AHA)	48
American Society of Plastic Surgeons (ASPS)	52
The Docs4PatientCare Foundation	53
Infectious Diseases Society of America (IDSA)	57
Medical Group Management Association (MGMA)	61

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WEDNESDAY, JULY 13, 2016

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:06 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Crapo, Cornyn, Thune, Burr, Isakson, Portman, Toomey, Heller, Scott, Wyden, Stabenow, Nelson, Menendez, Carper, Bennet, Casey, and Warner.

Also present: Republican Staff: Chris Campbell, Staff Director; and Brett Baker, Health Policy Advisor. Democratic Staff: Joshua Sheinkman, Staff Director; Michael Evans, General Counsel; Elizabeth Jurinka, Chief Health Advisor; and Beth Vrabel, Senior Health Counsel.

**OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S.
SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE**

The CHAIRMAN. I would like to welcome everyone to this morning's hearing. Today, the committee will hear from the Centers for Medicare and Medicaid Services on its initial proposal for implementing the physician payment reforms included in the historic Medicare Access and CHIP Reauthorization Act of 2015, generally referred to as MACRA.

I would like to thank Acting Administrator Slavitt for appearing today to testify on this important topic.

The passage of MACRA was a tremendous bipartisan achievement that addressed longstanding and recurring problems under Medicare. It was, I will note, one of the first of many significant bipartisan accomplishments we have seen in the 114th Congress. Most notably, MACRA eliminated the flawed Medicare Sustainable Growth Rate, or SGR, formula.

As everyone here will recall, the SGR mandated significant cuts to Medicare physician payments that were, on a more or less yearly basis, averted by legislation to, quote, "patch" the SGR. Between 2002 and 2014, Congress passed 17 different laws to prevent the cuts from taking place. The perpetual SGR cycle took up far too much of Congress's time and diverted attention from other priorities. Getting rid of the SGR not only resolved a vexing problem for

lawmakers, it gave security to Medicare beneficiaries who often had to wonder if they would eventually lose access to their physicians.

In addition to repealing and replacing the SGR, the MACRA law contains structural reforms to the Medicare program, including increased means testing for Part B and Part D premiums and limits on, quote, “first dollar” Medigap coverage for new beneficiaries.

While these structural changes put Medicare on a more solid fiscal footing, more needs to be done to ensure the program is there for future generations.

I note these reforms today to reiterate what I have said on several occasions. Despite the cries of naysayers, bipartisan Medicare reform is possible, and the passage of MACRA proves that to be the case.

I look forward to continuing the discussion on how to shore up the Medicare program for the long term. But for today, let me turn back to the stated purpose of this hearing, which is MACRA’s physician payment reforms.

The physician payment reforms are the result of years of effort in the Finance Committee. Working with the House committees of jurisdiction, this committee was able to craft a legislative solution that garnered the support of nearly every national and State physician organization.

This proved to be key to MACRA’s enactment, as previous efforts to eliminate the SGR had been stymied by the question of what would replace it. These reforms were intended to accomplish several things. Our most specific goals were to, one, streamline disjointed incentive programs to reduce the administrative burden on physicians; two, ensure that metrics on which physicians are assessed are relevant to the patients they treat; three, provide flexibility to physicians to participate in a way that best fits their practice situation; and, four, provide an incentive to consider and attempt alternative payment models.

Now, we are here today to discuss and, hopefully, evaluate how CMS has proposed to implement the law in order to achieve these goals.

Let me say that I appreciate the extent to which CMS has reached out to stakeholders to get their thoughts in advance of the proposed rule the agency released in April. I understand that CMS continued its outreach during the public comment period to ensure that key groups would be informed on the proposal and to hear their reactions. Consultation with stakeholders, especially beneficiaries and physicians on the front lines of providing care is precisely what we sought when we drafted the statute.

I also appreciate the outreach that CMS has undertaken with members of Congress and their staffs. Viewing implementation as a partnership with Congress is the right way to go. Without delving too far into my longstanding concerns about the administration’s lack of disclosure and cooperation with Congress, I say that I wish this model would be used more often.

The CMS proposal that resulted from this consultation and outreach is hundreds of pages, and the details matter greatly to our physicians and patients. This hearing will give CMS a chance to describe its implementation efforts and give members of the com-

mittee an opportunity to reflect and ask questions on issues that are garnering significant comment and public discussion.

It will also allow members to speak to Congress's intent with regard to MACRA, share insights, and hopefully get answers on the issues that are important to their constituents.

Before we hear from Mr. Slavitt on CMS's implementation, though, I want to flag an important concern that I know is shared by others, which is the plight of small and rural physician practices. We recognized the inherent challenges of these types of practices when we crafted the MACRA statute, and I know CMS is aware of these issues, but we need to make sure that the law is implemented in a way that works for these physicians and ensures that these practice settings remain viable options for Medicare beneficiaries.

So I look forward to a constructive dialogue here today and to the committee's continued engagement with CMS through the final rule in November and beyond.

With that, I want to recognize my partner and companion in this effort, Senator Wyden, for his opening remarks.

[The prepared statement of Chairman Hatch appears in the appendix.]

**OPENING STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON**

Senator WYDEN. Thank you very much, Mr. Chairman. Thank you for scheduling today's hearing.

It is my view that there are big opportunities ahead to make substantial bipartisan progress when it comes to protecting and updating the Medicare guarantee, and that is what this committee will be discussing this morning.

The first is to implement the plan to throw in the trash can the hopelessly broken, out-of-date Medicare reimbursement formula known as the SGR. This was the source of uncertainty and frustration for health-care providers and seniors, and it has now been sent to the dustbin of history.

Today, the committee has a chance to talk about how its replacement is going to be implemented.

Second, it is important to build on the new Medicare payment system, and, in my view, the obvious place to start is in the area of chronic care.

Seniors suffering from these chronic illnesses, such as heart disease, cancer, diabetes, and stroke, now account for 93 percent of the spending in the Medicare program. I am very glad that it is now a bipartisan focus of the committee.

By finally clearing the decks of the SGR debacle, the Finance Committee has been able to get to work on developing legislation that will empower families and Medicare to manage and treat these debilitating illnesses.

I would like to especially thank the chairman, Senator Warner, and Senator Isakson, who joined me in a special focus on this issue. This effort has already begun paying dividends.

Last Thursday, for example, the Centers for Medicare and Medicaid Services proposed to adopt, by rule, four of the proposals developed by our chronic care working group. The four areas relate

to diabetes prevention, care coordination among providers, mental health/substance abuse treatment, and Alzheimer's care planning, which reflects the special priority of our colleague from Michigan, who has done great work with respect to Alzheimer's.

Obviously, there is still an enormous amount of work to be done, but I just want to express to my colleagues my appreciation for the good work that they have already done, which, in my view, has been the spark behind what the Centers for Medicare and Medicaid Services proposed last Thursday to do by rule.

Now, when it comes to replacing SGR, Medicare payment reform took the important step of engraving into stone the principle of rewarding medical care that provides quality over quantity. For the seniors who depend on the Medicare guarantee, this ought to result in better, more thoughtful care. That is the direction health care is headed across the country, and Medicare ought to be leading the way.

I am going to wrap up by just making two quick points with respect to implementing the Medicare Access and CHIP Reauthorization Act the right way.

The first is to make sure all doctors who care for older people get fair treatment under the new rule. As Chairman Hatch and I have noted on many occasions, that is especially true for the small or solo practitioners who have always been the backbone of rural communities.

Second, the legislation supports efforts to strengthen primary care—which I believe, once again, there has been bipartisan support in this committee for—focusing there in order to help people to be healthier and to hold down costs. For example, the Comprehensive Primary Care Plus model allows Medicare to partner with commercial and State health insurance plans, so all parties are on the same page when it comes to paying for value and quality care.

What it means is a primary care doctor who has business in the commercial market and in Medicare does not have to find a balance between a byzantine set of rules as she is trying to serve as many people in her community as possible.

If done right, these kinds of innovative changes to the way doctors are paid are going to improve care for seniors in the program, and that is, of course, what the reform legislation was all about.

Finally, I would like to thank Mr. Slavitt, Andy Slavitt, Acting Administrator of the Centers for Medicare and Medicaid Services, for joining the community. He has been committed for a long, long time to doing right by the millions of Americans who have to navigate our health-care system each day, and we very much appreciate his push for more value and quality in American health care.

Thank you very much.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. Thank you, Senator.

Now, I would like to take a moment to once again introduce today's witness, Acting Administrator Andy Slavitt.

Mr. Slavitt is the Acting Administrator for the Centers for Medicare and Medicaid Services. He is responsible for overseeing the coverage of 140 million Americans under Medicaid, Medicare, the

health insurance marketplace, and the children's health insurance programs.

Prior to joining CMS in July 2014, Mr. Slavitt spent over 2 decades working in the private sector. Most recently, Mr. Slavitt served as group executive vice president for Optum. Prior to that and in reverse chronological order, Mr. Slavitt served as CEO of OptumInsight, founded HealthAllies and served as its CEO, assisted McKinsey and Company as a strategy consultant, and, finally, worked as an investment banker for Goldman Sachs.

Mr. Slavitt graduated from the Wharton School and the College of Arts and Sciences at the University of Pennsylvania and later received his master of business administration from the Harvard Business School.

Mr. Slavitt, please proceed with your opening statement. We are happy to have you here, and we welcome you to the committee.

**STATEMENT OF ANDY SLAVITT, ACTING ADMINISTRATOR,
CENTERS FOR MEDICARE AND MEDICAID SERVICES, DE-
PARTMENT OF HEALTH AND HUMAN SERVICES, BALTIMORE,
MD**

Mr. SLAVITT. Thank you. Good morning, Chairman Hatch, Ranking Member Wyden, and members of the committee. Thank you for the opportunity to discuss CMS's work to implement the bipartisan Medicare Access and CHIP Reauthorization Act of 2015.

We greatly appreciate your leadership in passing this important law, which gives us a significant opportunity to move away from the annual uncertainty created by the Sustainable Growth Rate to a new system that promotes quality, coordinated care for patients and sets the Medicare program on a more sustainable path. You will hear this morning that we remain open to alternative approaches that achieve these objectives.

Thanks to Congress, MACRA offers a new approach where every physician and clinician will have the opportunity to be paid more for providing higher-quality care for their patients.

In recognition of the diversity of the different practices, Congress created two paths. The first allows physicians and other clinicians to participate in a single simplified program with lower reporting burden and new flexibility in delivering quality care. The second recognizes the physicians and clinicians who choose to take a further step toward care coordination by participating in more advanced approaches, like medical homes.

Our approach to this implementation rests on the belief that physicians and their care teams know best how to provide high-quality care to our beneficiaries, and we have taken an unprecedented effort to draft a proposal that is based directly on input from those on the front line of care delivery, and we continue this dialogue with physicians and clinicians to help us understand how the changes we are proposing may positively impact care and allow us to reduce unnecessary burden.

In over 200 sessions throughout the country, we met with 64,000 attendees and have received nearly 4,000 formal comments from a wide range of stakeholders, demonstrating, I believe, the deep level of engagement from patients, physicians, and other clinicians in

working with us to build a system that is more supportive of good patient care.

We have learned a lot in that process and continue to engage directly with front-line physicians and patients.

I will now review five of the bigger themes that we received input on.

First, we must make the patient the focus throughout this program. Patients want to see policies that allow them to participate in the overall vision of improving and coordinating their care. Physicians want to see a program that supports them in patient care, not a new compliance program. This committee's leadership, in particular your focus on how we can best care for those with multiple chronic conditions, as Senator Wyden has discussed, has been instrumental in guiding us.

Second, we need to simplify the program and reduce burden wherever and whenever possible so that physicians can focus on patient care, not on reporting or scorekeeping.

Third, as new advanced approaches, like medical homes, are established, we need to create pathways so that more and more physicians and other clinicians can participate in these models. We will continue to work with the physician community to create more opportunities for physicians to participate in tailored programs, like our recently announced oncology care model, which provides a holistic coordinated approach to supporting cancer treatment.

Fourth, we must design the program with special consideration, as Chairman Hatch has said, for small and solo independent practices. Small practices do not have the resources that the large health systems do, and each new administrative requirement takes time away from patient care.

Fifth and finally, commenters asked us to consider what flexibility we have to allow the physician and clinician community time to learn and prepare for these changes. While the quality payment program builds on programs that should be familiar to clinicians, such as the existing quality reporting system, we understand that the new rules require adjustment and preparation.

All of this input serves as a valuable guide as we determine what adjustments are necessary in the final rule we will release this year. We should acknowledge that physicians have many frustrations and challenges with the current health-care delivery system, and implementation of this law will not resolve them overnight.

We will continue to need real and direct feedback from physicians, clinicians, and beneficiaries, and from you and the rest of Congress, on what is working and what should be adjusted. The launch of this program is only the first step of a larger process.

I will close by saying I have had the privilege of serving as CMS's Acting Administrator as we celebrated the 50th anniversary of Medicare and Medicaid last year, and I believe that the foundations we are laying over the next several years with the new patient-centered payment system will help set a sustainable, higher-quality path for the next 50 years of Medicare beneficiaries.

That is our clear focus in our implementation of MACRA, but it will take continued work and high levels of engagement to get it right.

I look forward to your perspectives about our implementation and to answering your questions.

Thank you.

[The prepared statement of Mr. Slavitt appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Slavitt.

Physicians are concerned that they will not have enough time to prepare to effectively participate in the new MACRA incentive payment program when it starts on January 1, 2017.

Assuming that CMS releases their final incentive program rule around November 1st, physicians would only have about 2 months before the program goes live.

I am sure there are pros and cons to any such start date, but this seems to be, to me at least, a legitimate concern. Considering that the MACRA law does give CMS flexibility as to the start of the physicians reporting period, what options is CMS considering to make sure this new program gets started on the right foot?

Mr. SLAVITT. You are exactly right. I want to begin where you ended. We need to launch this program so it begins on the right foot. That means that every physician in the country needs to feel like they are set up for success.

So this has been a significant source of feedback we have received as well, and I would start by saying we remain open to multiple approaches.

Some of the things that are on the table—and we are considering including alternative start dates—are looking at whether shorter periods could be used and finding other ways for physicians to get experience with the program before the impact of it really hits them.

The CHAIRMAN. Your statement describes four principles that guide the agency's implementation of the MACRA physician payment reforms. While I agree with all four, I want to highlight one here.

To paraphrase, you state that financial incentives should work in the background and that the focus must be on patients and not measurement. Now, this principle is consistent with one of the main tenets of the MACRA reform: the streamlining of disjointed programs for the disposition of administrative burdens.

CMS has proposed a number of good steps to eliminate redundancy, but I personally believe more needs to be done.

Can you describe opportunities for improvement in this area to ensure that these programs support rather than detract from patient care?

Mr. SLAVITT. I think we all have a shared national goal to simplify the health-care system, because there are really only two tasks that physicians have to do every day. They are either seeing patients, or they are doing some form of paperwork.

So the less time we can have them focused on the latter, the more time they will have to take care of the people who really need to be taken care of.

MACRA, as you have said, takes a big step in this direction by taking three disjointed programs and streamlining them into a single program. So even at the outset, there are some gains for physicians.

But it is a long journey to continue to simplify the health-care system, and we have solicited a lot of input in this area and we are open to lots of ideas, such as figuring out how to reduce the need for reporting at all. We have some categories where we can get automatic data feeds from physicians and do not need to ask them to report.

There are other areas where we know physicians are performing well, so we do not need to have them report on this at all.

We are looking at areas where we can exempt physicians or look at thresholds for physicians who do not see lots of Medicare patients.

So there are a variety of ideas that have been coming to us, and they are all really on the table at this point.

The CHAIRMAN. Thank you. As I said in my opening statement, I commend CMS for reaching out to stakeholders and members of Congress as the agency crafted this initial proposal to implement the MACRA physician payment reforms.

Now, such an inclusive approach is consistent with the intent of the MACRA statute. I would also reiterate my statement that we all need to work together on a continued basis to ensure that implementation works for physicians and beneficiaries.

My view is that this will be a multiyear process, and, while we expect to see improvements from the proposed rule to the final policy for 2017, there will be an ongoing need for refinement. One step that CMS could take to ensure the continuation of the iterative dialogue is to publish an interim final rule this fall.

What is the plan to ensure that CMS is best positioned to improve the programs on an ongoing basis?

Mr. SLAVITT. I think that option, as well as other options, are on the table for us to consider as we continue to keep the feedback process open.

We know that this is a long-term process. We know that we are only taking the first steps in the first years of implementation. So we have to have processes that allow physicians to continue to provide feedback to us.

From our perspective, CMS needs to really shorten the window and close the gap between the actual practice of medicine and policy implementation. That really is our job, and I think this process has allowed us to get closer to that.

The CHAIRMAN. Thank you. My time is up.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Mr. Slavitt, of course, what our committee has learned is that this is not our grandfather's Medicare program. Back when I was with the Gray Panthers, we talked about Medicare when somebody had a broken ankle or a really bad case of the flu. Today, it is about chronic illness.

I noted 93 percent of the Medicare spending deals with chronic illness, and 75 percent—75 percent—deals with seniors who have four or more chronic illnesses.

Let us begin by getting your take on how the new MACRA law would begin to start paying benefits for older people. I have already described how going on to the next stage is something that has

been a priority for this committee, and we put it in the context of this proposed rule that you announced last Thursday.

But let us talk specifically about the law that has been adopted by the Congress. How do you envision it dealing with those seniors who generate 75 percent of the spend and have four or more chronic illnesses?

Mr. SLAVITT. Thank you, Senator Wyden.

Those statistics that you quoted and that you have continued to remind us of over the years really ground us and need to ground us in the implementation of both MACRA, as well as, as you just covered, some of the other policy work that we are doing.

New approaches to payment must emphasize the ability to coordinate care for people who have multiple chronic conditions and give physicians time to do that, and that needs to really be part and parcel of every one of the advanced models that we put forward.

We recognize that, as you say, the breadth of this issue extends even beyond MACRA, and your longstanding leadership has been instrumental to us, along with Chairman Hatch, in guiding our principles here.

I would also add that the bipartisan working group chaired by Senators Isakson and Warner has done the same as well, and I thank them.

I think we can point to some recent successes in this area. We have recently announced that we are going to be scaling the prevention of diabetes. We have launched an oncology care model for the treatment of cancer patients, which is directly a part of the MACRA implementation.

We have a proposal now to better care for individuals living with dementia, which I know has been a longstanding commitment and priority of Senator Stabenow. And of course, behavioral health and coordinated care become a part of all of these pieces.

So really we have to bake this into the fabric of every element of the models that are available to physicians under the MACRA law, because as you say, we are not dealing with people who are jogging and breaking an ankle. That is not the burden on the Medicare program. The burden is helping people who live with multiple chronic conditions.

Obviously, there are limits to what we can do administratively, and we know you have other areas of focus and ideas, such as expanding the independent home model.

So we stand ready to work with you in all of these efforts.

Senator WYDEN. Let me ask a question about the small practices and the opportunity to really deal with the burden and the complexity that the small practices and practitioners bring to every single member of this committee.

I can just tell you, having talked to virtually all of the members with respect to what they hear when they are home, this is what comes up constantly with respect to the complexity and the burden.

You all have proposed creating virtual groups—virtual groups that would allow individual physicians to report together. In effect, it might be a low volume threshold, and then these providers in rural areas could report together. That strikes me as pretty promising stuff.

Now, there are a lot of pieces to the puzzle, because we have to make sure that they have good broadband connections and the like.

But tell me a little bit about how you envision that working, particularly giving the flexibility to these small practices that they are asking for and that I think is in the spirit of your proposal.

Mr. SLAVITT. Yes. Thank you for asking that question, because the focus on small, independent practices and their ability to continue to practice independently is a very high priority for us. And I would add, it is not just small practices. It is also any physician who practices in a rural location. They have a very different set of dynamics than other physicians do, and many of our beneficiaries, of course, live in those areas.

So we need every physician to be set up for success, and the challenges in small practices are far greater. Oftentimes, in a small practice, you will find it is a physician and his or her spouse and that is it. That is all the work that they do. So if we add additional paperwork, that paperwork comes out directly from patient care.

So there are a number of areas where we receive feedback in talking with small practices and visiting directly with small practices, including, how do we compare the performance and evaluate the performance of small physicians; how do we lessen the reporting burden; how do we look at things like thresholds, as you said.

We have solicited direct feedback on what the best way to create virtual groups might be. So we remain very open in this area. We think there are a number of steps that are available to us, and we will continue to seek input in this area.

The CHAIRMAN. Senator Stabenow?

Senator STABENOW. Thank you very much, Mr. Chairman and Ranking Member, for a very important hearing.

Welcome, Mr. Slavitt. It is great to have you with us.

First, just a couple of comments. One, I want to thank you, as I have done privately, for working with us and coming forward with a number of proposals, certainly behavioral health being incredibly important. But as it relates to dementia and Alzheimer's, focusing on caregivers and being able to create a system for payment incentives around caregiver planning sessions is really, really important and is based on what we have been working on, bipartisan legislation, for a number of years, called the HOPE for Alzheimer's Act.

So we are very, very pleased that we have 57 members of the Senate as cosponsors of this. So it is something that I am anxious to work with you on as you move through the comment period and so on, to be able to get this into practice as soon as possible.

The other thing I want to mention as well, more of a concern, is the home health demonstration project. Continue to monitor that closely in terms of whatever is done, increasing accountability to make sure it does not get in the way of people being able to get home health care, which is critically important.

The issue today, MACRA, is really a historic piece of legislation. We all want very much for people to receive the best health care possible, and we know that a health-care payment system that rewards doctors for doing their job also improves patient outcomes and saves taxpayer money. It is a win-win, providing quality patient-centered care; we know that.

So the question is, how do we get there? We also know the current fee-for-service model is outdated and less effective than a value-based outcomes-oriented approach. But I also know that if we surveyed everyone in the room, we would have different ideas of what that meant, which is the challenge, I think, for you and for all of us going forward.

But if we get it right with innovative approaches, we are actually going to see patient outcomes and quality care go up and costs go down. So it is important for doctors and seniors and families and communities and hospitals and providers.

I want to ask for your comments on a couple of specific issues, though, that I am hearing about from providers in Michigan. They dovetail with what the chairman and ranking member have talked about.

The first one is electronic health records. As we talk about small practices, as we talk about rural communities, like in northern Michigan and the upper peninsula of Michigan, that may not have access to the technologies that APMs or the MIPS program require, we know that in order for doctors to participate in Alternative Payment Models to coordinate care, it is really important that electronic health records be easy and quickly able to operate, to be able to do what needs to be done. Interoperability is critically important.

So what is CMS doing to make sure rural providers are able to fully engage in these two models we are talking about: the MIPS—the fee-for-service—and the Alternative Payment Models reimbursement tracks, given their restrictions, especially as it relates to electronic health records?

Mr. SLAVITT. Thank you, Senator Stabenow. The good news, I think, for all of us as a country, compared to where we sat 5 or 6 years ago, is today over 70 percent of physician practices have electronic medical record technology in their office and virtually all hospitals do today.

That is a significant step forward. However, we have more work to do in that those electronic medical records, by most reports, are not yet easy to operate and they are not yet able to move information back and forth between one physician and another or a physician and a hospital when a patient moves, and that makes it much more difficult.

So we have attempted to focus in a couple of areas here. First is really to lessen the requirements, and particularly the requirements on the types of physicians that you refer to, in terms of complying with the program that allows them to qualify for use of electronic medical records.

We have increased flexibility. We have lessened the burden. We have created more options, and we think that is going to be helpful.

We have also focused virtually all of the measures now on interoperability; that is, the ability of a technology to move data between one system and another. Everyone has a role to play in that. The vendors have to comply with this, and we think that is going to ultimately be very beneficial to the physicians.

Senator STABENOW. But I would just indicate that 10–12 years ago, as we were first talking about this—and I was very involved in establishing this—I was very concerned there was not one stand-

ard on interoperability at the time, because I think it has added to the challenges that people have right now.

Let me——

The CHAIRMAN. Senator, your time is up.

Senator STABENOW. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Thune?

Senator THUNE. Thank you, Mr. Chairman.

Mr. Slavitt, I want to come back for a minute to the issue of virtual groups and talk a little bit about the timeline for that.

I am disappointed that the final rule punts this decision for another year, since the proposed rule indicates that clinicians would have to elect to be in a virtual group by June 30th of the year before.

Could you provide us with a time frame for when CMS plans to issue a proposed rule on these groups?

Mr. SLAVITT. Thank you, Senator.

Virtual groups is an area that, going all the way back to January, we have solicited feedback from physicians on concerning how that might work, because we do agree with you that it is a concept that has a lot of promise and a lot of potential. But because it is a new concept, there are a lot of details to work out, and we want to make sure that when we launch it, we launch it right.

So in the first year, I think we have the opportunity to launch a number of things that are helpful to small practices, some of which I have talked about, including reporting thresholds, including things that make it easier to report, some performance improvements, and so forth, while we continue to work with physician groups on the launch of virtual groups.

I think you are right. I think this is going to be a high priority for us, and I think it is going to be something that is going to need a lot more input from physicians to make sure we get it right.

Senator THUNE. Could you maybe specifically identify what issues and barriers CMS has identified that are prohibiting these groups from going live next year and how it plans to overcome them next year?

Mr. SLAVITT. It is just a whole new way of reporting, and we need to make a number of decisions—and physicians would need to make a number of decisions, and they are not yet used to practicing that way.

So we have asked physicians, “How might you want to go about this?” and we have gotten a lot of the sense that, yes, this has promise, but we have to be able to make a whole lot of decisions, let alone implement the operations and the technology to support them.

So I do not think this is something that cannot be solved with just a little bit more time, but it is certainly not something that is ready to be launched in 10 months.

Senator THUNE. Can you give us some sort of time frame, though, when it might go live?

Mr. SLAVITT. I think our aim would be to get it done within the following year. That would be our aim. I want to make sure we do everything we can to get it right and get the feedback.

The thing I want to also make sure to convey is the reason why virtual groups are important. We think we are going to be able to

get them to small practices in the first year through other means as well.

Senator THUNE. I want to turn now to the issue of a low volume threshold. Being from a rural state, I am always contemplating how changes to reimbursement are going to impact rural providers.

The proposed rule attempts to create a low volume threshold, but I am not quite sure it provides enough flexibility.

Clinicians eligible for the exemption must have Medicare billing charges of less than or equal to \$10,000 and provide care for 100 or fewer beneficiaries. This dual requirement seems especially low, especially the \$10,000 threshold.

The question is, is there anything else that CMS can do to ensure that rural providers have access to a meaningful low volume threshold exemption?

Mr. SLAVITT. Yes, Senator, that is an area where we have received a lot of particular input. I think a lot of people feel that the \$10,000 number is too low. So we are currently looking at that—that is very much on the table—to figure out what is the right way to define that threshold.

But certainly, at some point, the juice has to be worth the squeeze, and if a physician is not seeing enough Medicare patients for this program to be meaningful, we should not require them to go through the process.

Senator THUNE. The recent Medicare trustees' report estimates that the Independent Payment Advisory Board, or IPAB, is going to be triggered in 2017 with implementation of these cuts required in 2019.

How do you think that is going to impact MACRA implementation?

Mr. SLAVITT. I cannot speculate on that yet, because I think we have not triggered IPAB, as you know, this year. So I think that that is something that the next Secretary will face, if they are in that position next year.

Senator THUNE. Would you support repealing IPAB to protect providers and beneficiaries who would be faced with these arbitrary cuts?

Mr. SLAVITT. No. I do not think that is the administration position on IPAB.

Senator THUNE. I know it is not the administration's position.

Mr. SLAVITT. Thank you. [Laughter.]

Senator THUNE. As you know, there is going to be a new one coming in, though. You could kind of go solo now, go rogue, and actually give us your opinion.

Thank you, Mr. Chairman.

Mr. SLAVITT. Thank you, Senator.

The CHAIRMAN. Thank you, Senator.

Senator Menendez?

Senator MENENDEZ. Thank you, Mr. Chairman.

Thank you, Mr. Slavitt, for coming before the committee.

Let me say, thankfully, the days of being on the SGR doc fix merry-go-round are behind us, and I, for one, want to make sure that we do not find ourselves in the same position again, a position that requires regular congressional intervention to maintain con-

sistency in Medicare payments and, ultimately, consistency in access to care for seniors.

So with MACRA, we have a great potential to change the paradigm around both payments and practice design with the establishment of the alternative payment methods.

These models could ultimately end the fee-for-service model once and for all, leading to a purely quality- and value-based reimbursement system. However, to fully realize this goal requires a substantial number of physicians moving into these alternative practices and taking on some financial risks associated with their quality resource use and outcomes.

While this two-sided risk provides a serious incentive to achieve high quality, it is unclear how many physicians will actually choose or have the ability to move their practice into an advanced APM.

We have recently seen that this type of two-sided risk arrangement has not had a lot of uptake—like the two-sided ACO models, which have less than enthusiastic enrollment.

So what analysis has been done to take into consideration providers' willingness or ability to move into two-sided risk Alternative Payment Models in the near term, or, in another sense, how many practices will, in essence, forego even trying to get into an APM and just maintain fee-for-service through the MIPS program in perpetuity?

Mr. SLAVITT. Thank you, Senator. As you point out, we are on the beginning of a journey to move toward a new set of models that allow physicians more freedom to practice more coordinated care, more team-based care, and give them the flexibility to get rewarded for quality.

I think it is important to remind all of us that we are very much in the early years of these programs, with just, I think, the first and second generation models out today.

But the good news is, we are beginning to see these approaches begin to work. We are seeing physicians increasingly move into two-sided risk models. I do think we have to be thoughtful and judicious about how we define two-sided risk, so that it is not so intimidating to physicians, and make it available to more physicians to join, which I think is your suggestion.

Over the next several years, I think it is our task to work with the PTAC, which is the physician advisory committee that has been set up by the Congress, to get more and more models so there are more and more options, such as our oncology model for cancer and other specialties across the spectrum.

We have received meaningful feedback on this topic, both on how to judge qualifications for more than nominal risk, as well as how to get more advanced models in, and that is currently a focus.

Senator MENENDEZ. Can you quantify that for me at this point?

Mr. SLAVITT. Can I quantify—

Senator MENENDEZ. The number of physicians who are actually beginning to move in this direction.

Mr. SLAVITT. Yes, and I think I can get you a more precise number. But if I look at our largest population-based model, which is called the ACO, I think we have 20 percent to a quarter of those that are now in two-sided risk models, up from a much lower number a year ago.

I am not sure that is the precise number, and I will follow up with you. But that is pretty encouraging.

Senator MENENDEZ. What other major changes to physician practices, like the proposed Part B drug payment demonstration, factored into the analysis that you have done about the potential here?

Mr. SLAVITT. Your question is, what has the Part B demonstration—

Senator MENENDEZ. What other major changes to physician practices, like, for example, the proposed Part B drug payment demonstration, factor into your view as to how the acceptance is going to be among physicians in this regard?

Mr. SLAVITT. I think there are two things. One is, I think we will have a number of, and we will continue to have a number of, limited demonstrations that come out of our Centers for Medicare and Medicaid Services, because part of what we are tasked with is figuring out what works and can be expanded upon and what does not.

So that will continue to go on, and I think we will ultimately create models and approaches that will allow us to offer new, advanced Alternative Payment Models.

At the same time, I think we have to also be conscious of the fact that we are putting an awful lot of change into the system and on physician practices, and too much change on top of an already-burdened physician practice is just not where we should be going.

One of the reasons we are interacting so heavily with the physician community and the patient community is to reduce the burden at the same time that we are working through some of these changes, and then to modulate these changes in ways that really make sense to physicians so they can support the patient.

I think it is very important for all of us not to get wrapped around the axle with these models and so forth. What we have to continue to be focused on is the physician and the patient and that these models need to work in the background so that the physician can be successful.

The CHAIRMAN. Senator, your time is up.

Senator Isakson?

Senator ISAKSON. Thank you, Mr. Chairman.

Mr. Slavitt, I want to thank you for two things. One, first of all, Senator Warner and I worked very much on care planning for a couple years, and I want to compliment CMS on creating a code and reimbursement for care planning, reimbursement for physicians working with seniors to plan the kind of treatment they want when they are capable of making those type of plans. That was a great move on your part, and I appreciate your doing it very much.

Also, on the chronic care working group, Senator Wyden and Senator Hatch have been tremendously supportive of what Senator Warner and I have been doing on care planning. As you know, we have had 1,300 inputs now from stakeholders. We are about 18 months into that process, and we are at the point where CMS and CBO are working together to come up with the scores that are necessary for us to finish the product.

About 10 days ago, Senator Warner and I met with the staff, who told us there were some difficulties getting a type of information

from CMS to CBO to get the final scoring done. But I understand in the last 10 days, you all have done yeomen's work doing that. I wanted to thank you for that and hope you will continue to do so, because it is critical that we get that score so we can finish that paperwork.

Mr. SLAVITT. Yes, we agree. And I think our staff has been very engaged in that.

Senator ISAKSON. Thank them, if you will.

Mr. SLAVITT. I will, yes.

Senator ISAKSON. I was going to ask you a question about small and rural practices, but if I am correct, every single member, except Senator Menendez, has asked you that question, and every time you have responded that you are aware of the problem.

So let me just say on behalf of the Medical Association of Georgia and all the rural doctors we have outside Atlanta, anything you can do to help make this MACRA less burdensome for them will be greatly appreciated.

Mr. SLAVITT. Yes, Senator, absolutely.

Senator ISAKSON. I guess last, let me just say this. Under the framework of the proposed MACRA rule, 87 percent of solo physician practices face negative payment adjustments in 2019, the first year of the merit-based incentive payment system, or MIPS. Ending the cycle of possible Medicare premium cuts and uncertainty in Medicare, which we accomplished by doing away with SGR, was the goal of doing this.

The intent of the law was not to penalize physicians simply because of being in a small practice or being in a certain specialty, but MIPS was designed because CMS, at this point, just seems to do that.

What are you doing to try to neutralize that effect?

Mr. SLAVITT. Thank you. And that would not be an acceptable outcome. What we have learned are a couple things. One is that physicians in small and rural practices, when they report, can do equally as well as larger-sized, mid-sized practices.

So that is the good news. I think what that tells us is that we have to make the process of reporting easier. It is relatively easy for large practices to report because they have large staffs. So we have to make it much simpler for smaller practices to be able to report.

We have a number of ideas for being able to do that, some of which include being able to get information automatically, some of which will allow us to work with places where physicians are already submitting data, for example, to a clinical registry, and just take that data from that registry.

So the aim is to not require a whole lot of paperwork and data entry from physicians so they can focus on patient care.

I think if we do that—and the evidence has begun to show, as physicians are able to report more, we are seeing that they are not getting penalized. So over this comment period, we are continuing to work through those ideas.

Senator ISAKSON. Thank you for the answer, but, in particular, thank you for the support on what we are trying to do on chronic care. We appreciate your cooperation.

Senator MENENDEZ. Would the Senator yield just for a moment?

Senator ISAKSON. Certainly.

Senator MENENDEZ. I would be happy to invite my dear friend and colleague to southwestern New Jersey, where we have cranberry bogs, peach orchards, blueberries, and there are rural parts of the State. So we have a concern that I share with you in that regard.

Senator ISAKSON. And it is prettier than Newark, I can tell you that. [Laughter.] Rural New Jersey is fantastic; I love it.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Casey?

Senator CASEY. Thank you, Mr. Chairman.

Mr. Chairman, you know how many counties in Pennsylvania are considered rural counties, with your roots in western Pennsylvania. So let me add my voice to those concerns that were raised.

I want to focus on one primary topic, though, for my one or two questions—socioeconomic status, so-called SES, of beneficiaries.

We are talking about low-income folks and the quality rating impact that those folks have when those beneficiaries are accounted for, the impact a high number of low-SES beneficiaries would have on quality ratings.

I just want to read some of your testimony. On page 4, you outline four principles that will guide implementation. The second principle indicates as follows: “Success will come from adopting approaches that can be driven by a physician practice. Quality measures need to accurately reflect the needs of a diverse range of patient populations and practice types and give physicians and other clinicians the opportunity to select elements of the program in measures that are right for their practice.”

So a diverse range of patient populations and practice types and a focus on what would be right for their practice.

My basic question, with that predicate of your principles, focusing on low-SES beneficiaries, is what steps have you taken to help practices that treat a high number of these beneficiaries achieve both fair and accurate quality ratings?

Mr. SLAVITT. Thank you, Senator. You point to an important priority for the agency, which is that the Medicare program’s biggest challenges are not 67-year-old joggers with three Fitbits. They are people who live two bus stops away from their dialysis appointment and have, as we talked about this morning, four chronic conditions.

So it is very important to us to make sure we support the physician who wants to treat those patients. We know that that is a harder challenge.

So in everything we do, we have to figure out how to account for that. Now, it is complicated, because there is no straightforward way to do it always, but we just completed, I think, a very significant piece of work in the Medicare Advantage program to adjust how the Medicare Advantage program pays so that we can essentially reimburse higher for taking care of people in exactly the kind of situations that you talked about.

We have to continue to make that march happen across the entirety of the program. One vital step which is part of MACRA is simply to do risk adjustment, which means that if two patients come to see a physician and one of them has four chronic condi-

tions, that there will be a higher reimbursement in acknowledgement of the fact that that is a more complex situation.

That is baked into elements of MACRA. Do I think there is more we can do? Yes. I think as we learn more and as we understand more how these models work, we will be able to do that.

We have a piece of work, a study that is being completed in September around this very topic, coming out of the Assistant Secretary for Planning and Evaluation's office. I am eagerly awaiting that report, because I think we can incorporate those themes into this and other pieces of our work.

Senator CASEY. I appreciate that. I have been working for a long time with Senator Portman on this. So we are grateful for that work.

Let me end just by putting in a little bit of a commercial, a commendation for the State Children's Health Insurance Program, which we know here by the acronym S-CHIP. But it is one of the most successful programs of any kind, not just health-care programs, in our Nation's history—160,000 Pennsylvanian's were approaching the quarter-century mark in our State for S-CHIP.

So I know you place a heavy emphasis on that program, and I just urge you to keep doing that. We can follow up with something for the record on the Children's Health Insurance Program.

Thank you very much for your work.

Mr. SLAVITT. Thank you, Senator.

The CHAIRMAN. Senator Warner?

Senator WARNER. Thank you, Mr. Chairman.

Thank you for your good work on MACRA, Mr. Slavitt. It is good to see you again.

The goals of MACRA are great. The complexity of getting it right is going to be an enormous challenge, and I commend you for your work so far.

I want to, first of all, follow up on a couple comments that my friend, Senator Isakson, made. He is a real gentleman, and he has been a great partner on a number of these projects.

I would like to nudge you a little more. The chairman and the ranking member and Senator Isakson and I have been really aggressively working on this chronic care package. We all know the data. Over 90 percent of the Medicare costs arise from these chronic care patients.

The challenge, if we are going to move this legislation, hopefully in the early fall, is to get this scoring done, and my hope is—you do not have to say it to me right now—that you can get us a timeline on when we would get that scoring completed so I can share it with the chairman and the ranking member, because the chairman has expressed great interest in moving forward on this as well.

So if I can get back to you in the next 24 hours and you can get me some feedback on when that scoring will be done, I would appreciate it.

Mr. SLAVITT. You have our commitment on that.

Senator WARNER. Thank you.

I also want to echo what Senator Isakson said on an issue that I have been involved with since back when I was Governor, and that is the whole question of advanced care planning.

Obviously, this is a challenge every family goes through. I think, candidly, the public is way ahead of the elected officials on sorting through this, and, again, I want to commend you for putting in a CMS code on that kind of consult.

Senator Isakson and I have an Advanced Care Planning Act that would move beyond that in terms of moving into this field and making sure families make informed decisions based on their values and choices.

Clearly, around Alzheimer's, you have made progress. But as you think through the quality measures within MIPS, how do you get it right to also reflect the priorities of the Medicare beneficiaries and their families at that important stage of life?

Mr. SLAVITT. One of the things that is really important to us is that we get out of the mode of just feeling like we are paying physicians to cut, test, or prescribe, because as you point out, if we do not also begin to pay physicians to have conversations and talk about the cognitive issues, whether they are advanced planning issues or whether they are issues of how people are managing the chronic conditions that they are living with, we are not going to make that kind of progress, both short-term and long-term, that we need to make.

So models like medical home models—which provide a care coordination fee within a small practice that could not otherwise afford the resources to invest in things that allow them to call patients at home, check on how they are doing, make sure they are taking their medications, see what barriers exist, whether they are social or clinical—are very, very important.

I think the more and more of these advanced models that are part of MACRA, the more successful we are going to be in this whole array of both chronic topics, as well as other topics that require physicians to spend their time the way they and the patients really want them to spend it.

Senator WARNER. I would simply say that part of this—the chronic care and, also, the advanced care planning and trying to make sure that if a family does sit down and create an advance directive or a POLST—is that the docs and hospitals are incented to actually follow that advance directive.

There are so many heartbreaking stories we have heard of family members, oftentimes daughters, having to intervene to make sure that mom's or dad's wishes are truly respected. It is terribly important.

Let me move to another subject with my last minute, something that has not been raised so far, but an area of importance to me. That is the whole intersection—as we sort through health care—of cybersecurity and protection of health-care records.

Ninety-four percent of medical institutions have said their organizations have been victims of a cyber-hack or cyber-attack. Under the proposed rule, you do recognize this, and a provider has to, quote-unquote, “protect” patient health information through security risk analysis and effectively check a box, and if they do not check the box, they do not get credit here.

But in a field that is so dynamic and constantly evolving, how do you make sure that that box checked, as cyber-threats continue to evolve, is going to be able to be monitored on an ongoing basis?

Mr. SLAVITT. Well, I think we have to place the burden on the people who can really do the most here, which is the vendors and the technology community. I think physicians and their willingness to attest to being careful with patient data—I think physicians take that very, very seriously.

So that is probably not the largest concern. The largest concern is to make sure that as we move to a world of electronic medical records, they continue to update and qualify for certification in the latest cybersecurity standards and that they do not get certified unless they pass the latest standard.

We are going to need to, to your point, continue to evolve that, because, unfortunately, the state-of-the-art of cybersecurity continues to move.

Senator WARNER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Toomey?

Senator TOOMEY. Thank you, Mr. Chairman.

Mr. Slavitt, thanks for joining us again.

I would just like to briefly mention that the last time you came before this committee, I think it was the last time, you expressed your support and the administration's support for the lock-in provision being provided to Medicare, a provision that would allow Medicare to identify and then do something about patients who are doctor-shopping for opioids, and I want to thank you for that support.

As you may know, that provision is included in the Comprehensive Addiction and Recovery Act bill that I think we are going to vote on perhaps later today, and I am very hopeful that that will pass, that the bill will pass. I think it has a very, very strong combination of mostly modest steps that we can take to deal with an enormously difficult and excruciating problem.

So, thanks for your support on lock-in.

I also want to thank you for responding to what several of us have observed, which is the previous policy, as I understand it, of linking somewhat Medicare reimbursements to hospitals based on the results of patient satisfaction questionnaires, which included questions about pain management.

It may be somewhat indirect, but the result was to create a financial incentive to over-prescribe opioids. My understanding is that there is going to be a discontinuation of the link between the response to the pain questions and the reimbursement level. Am I correct in understanding that?

Mr. SLAVITT. That is correct.

Senator TOOMEY. Has that gone into effect yet, or is it about to go into effect?

Mr. SLAVITT. It is a proposed rule. So we are seeking comments on that right now.

Senator TOOMEY. Will reimbursement levels still be somewhat a function of other questions on the patient satisfaction questionnaire?

Mr. SLAVITT. Absolutely.

Senator TOOMEY. They will. But no longer will the pain management question—

Mr. SLAVITT. That is correct.

Senator TOOMEY. I think that is exactly the right approach. I want to thank you for that.

The question that I want to ask is about the CO-OPs. I think just this morning, the latest CO-OP announced its failure. We are now, I think, up to 16 of the original 23, I believe, Obamacare CO-OPs having left the business.

I think in most cases, it is a simple bankruptcy, and I think they failed financially. And along the way, of course, their discontinued operation leaves hundreds of thousands of people without health insurance.

Taxpayers have put \$1.5 billion into the CO-OPs that have failed. That money is just gone. And I am wondering about the future of the remaining ones.

I guess my first question would be, has your staff advised you to expect further failures, additional CO-OP failures over the course of the remainder of this year?

Mr. SLAVITT. We are just now at the point where, in July, we are reviewing the June financials of the CO-OPs. I would say kind of an overarching point in the way that at least I think about the CO-OPs is that they are very small businesses competing against very large businesses, with low amounts of capital and, as a result, very low margins of error.

So we watch them month-to-month, and, more importantly, the States and the State departments of insurance, which are really responsible for having a bead on capital requirements, watch them as well.

I think when we do this, our priorities are twofold. One is to make sure that consumers are taken care of as best as possible and to support the States which really make a lot of those decisions.

Secondly, our job as a lender is to responsibly look after the capital that has been committed and go through a process with the Department of Justice to make sure that we recover funds when possible.

Senator TOOMEY. I understand. But my question was, has your staff advised you to expect further failures over the course of this year, or do you think we are done, that the remaining CO-OPs are mostly going to be fine? Do you have an opinion on that?

Mr. SLAVITT. I think it is a month-to-month focus for us right now. I think we are working closely with the existing CO-OPs. I think all of them, while successful in some measures, all of them have pretty low margins of error, and I think we need to watch them.

Senator TOOMEY. So something like 70 percent have already failed. I am told to expect there will be more failures.

When I look at the big insurers who are well-capitalized and extremely sophisticated, they are losing money hand over fist in this space, and I am worried that this is a manifestation of the adverse selection that some of us were afraid was going to occur, that it is happening.

Premiums are rising enormously in response to that. Do we not have a big problem in this whole space?

Mr. SLAVITT. I think my characterization would be that we have a wide variety across the entire spectrum, from some health plans that are making a lot of money and very successful, to some that

are either at break-even or close, to others that have been losing money and are going to be——

Senator TOOMEY. But a big majority are losing money, right? A big majority of these plans are losing money.

Mr. SLAVITT. I would say, as we sit here in 2016, that is not necessarily clear. But I think what is important is that this is a market that will evolve over the first 2 years. I expect some new entrants to come in. I expect some people to move out of markets. I think this is to be expected in a brand new market with a new set of rules.

I think what is important to us is that we have a model where people with preexisting conditions can get covered. People have to make adjustments when they have to cover people with preexisting conditions. We understand that. So we try to compensate for that by risk adjustment and other approaches, and we will continue to stay on top of it.

The CHAIRMAN. The Senator's time is up.

Senator TOOMEY. Thank you, Mr. Chairman.

The CHAIRMAN. We have a vote on, and Senator Carper will be our last, as far as I know.

Senator CARPER. Thank you.

The CHAIRMAN. I am going to go vote, and if you could wrap it up, I would appreciate it.

Senator CARPER. Yes, Mr. Chairman, I would be pleased to.

The CHAIRMAN. Mr. Slavitt, I am very grateful for your testimony and grateful for you taking time to be with us. I appreciate you being here.

Senator CARPER. Mr. Chairman, before you go, I just want to say Mr. Slavitt's nomination has been before the Senate, I think, for about a month. He has, as you know, a very, very hard job. I think he works hard for the money, he works hard for our money, and I would just urge us to move his nomination.

The CHAIRMAN. I understand.

Senator CARPER [presiding]. Having said that, I would say, Mr. Slavitt, thanks. It is very nice to see you. I thank you and your team very much for taking on a tough job and working at it so hard.

I want to thank you, also, for your help with the first Accountable Care Organization in our State and the work that you and your staff did to give the doctors in Delaware and in Maryland another chance to prove that they can deliver high-quality care. I think we will ensure that these doctors remain on the important path of moving away from fee-for-service and toward performance-based models, for which we also want to thank you.

In your testimony, I believe you noted that 30 percent of Medicare payments were already linked to Alternative Payment Models and that we soon hope to reach 50 percent of payments with these alternative models.

My question is, what type of Alternative Payment Models do you consider to be the most promising for improving health-care outcomes and lowering costs? And related to that, what obstacles prevent Accountable Care Organizations from shouldering more risk for their patients?

Mr. SLAVITT. Thank you, Senator. I think we are just in the first and second generation of seeing what new approaches work, that work better than fee-for-service. I think we all agree that the fee-for-service program is not the applicable system, and we have spent the last few years, as you pointed out, testing several different approaches.

I will name four really quickly. The first is a bundled approach where someone will come in for a procedure, and the entirety of their experience—inpatient, outpatient, rehabilitation, everything—can be covered under one payment. That, of course, encourages teamwork.

The second would be a team-based model, as you pointed out, like an accountable care model, where physicians are essentially incentivized to work together as part of a team to look at an entire populations' health. Those models, I think, have begun to show some real progress.

Third are models that are primary care-focused, like a medical home, where physicians can essentially take the time and have investments into care coordination.

Then, finally, I think a very promising development and maybe a more recent development is prevention models. We just launched and announced that we are going to be scaling a model that is a prevention model for diabetes. I think that is very exciting, very promising.

All of those four domains and possibly others, I think, will emerge over the next few years to hopefully provide a next generation of care for patients across the country.

Senator CARPER. Good. I would concur with you on the last one, because the prevention model is very encouraging. Thank you.

My other question relates to CMS stakeholder meetings. The new physician payment system is, as you know, fairly complicated to explain and for physicians to understand, for us to understand.

I am encouraged that you and your colleagues have held literally hundreds of stakeholder meetings, I think, throughout the country to collect feedback for implementing this new Medicare payment system.

Could you just share with us—not today, but in the days ahead—the schedule for future meetings so that we can let our own constituents know when they can participate, how they can participate?

The other thing I would ask is, what other types of outreach and interface are you considering to help physicians navigate this new payment system?

Mr. SLAVITT. To your first question, we absolutely will.

To your second question, we find with a law of this importance, almost the worst place for us to write the policy is here in Washington, and the best place is to get out in the field and visit physician offices.

So the types of places and the ways we have been conducting outreach range from sitting down in physician offices and having physicians share with us their experience with the programs that they have to deal with today, to focus groups, to day-long workshops and working sessions. And then what we have to do is en-

gage the people whom physicians trust the most to help them educate about this.

That is not necessarily going to be the Federal Government, it might surprise us. It is going to sometimes be the specialty society or the State medical society or some other organization that will be very knowledgeable about the program and that the physician can rely on for some advice in this area.

So part of our stakeholder engagement includes making sure that the people the physicians trust become as knowledgeable as they need to be and have a direct pipeline to us to get information.

Senator CARPER. Thanks. Thanks so much.

My staff just gave me this. The chairman has asked me, given my strong support for your confirmation, to ask unanimous consent that you be—no, just kidding. [Laughter.]

We are here on an otherwise dull Wednesday morning. No, not dull. Not dull at all.

I want to thank you for your testimony. We want to thank you for your testimony today.

We also want to thank our colleagues for their participation. This is, for all of us I think, a highly important meeting, and we hope that we can continue working with you and your folks as we seek to further improve the Medicare system.

I was with some folks from another industry today, and I said, “You have a really hard job,” trying to improve quality, quality outcomes, with value systems and prevention and so forth, and it is not easy. So we thank you for that.

I would ask that any written questions be submitted by Wednesday, July 27, 2016.

With that, this hearing is adjourned.

[Whereupon, at 11:19 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R-Utah) today delivered the following opening statement at a hearing to examine the Centers for Medicare and Medicaid Services' (CMS) implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA):

I'd like to welcome everyone to this morning's hearing. Today, the committee will hear from the Centers for Medicare and Medicaid Services on its initial proposal for implementing the physician payment reforms included in the historic Medicare Access and CHIP Reauthorization Act of 2015, generally referred to as MACRA.

I would like to thank Acting Administrator Slavitt for appearing today to testify on this important topic.

The passage of MACRA was a tremendous bipartisan achievement that addressed long-standing and reoccurring problems under Medicare. It was, I'll note, one of the first of many significant bipartisan accomplishments we've seen in the 114th Congress.

Most notably, MACRA eliminated the flawed Medicare Sustainable Growth Rate, or SGR, formula.

As everyone here will recall, the SGR mandated significant cuts to Medicare physician payments that were, on a more or less yearly basis, averted by legislation to "patch" the SGR. Between 2002 and 2014, Congress passed 17 different laws to prevent the cuts from taking place.

The perpetual SGR cycle took up far too much of Congress's time and diverted attention from other priorities.

Getting rid of the SGR not only resolved a vexing problem for lawmakers, it gave security to Medicare beneficiaries who often had to wonder if they would eventually lose access to their physicians.

In addition to repealing and replacing the SGR, the MACRA law contained structural reforms to the Medicare program, including increased means testing for Part B and Part D premiums and limits on "first dollar" Medigap coverage for new beneficiaries. While these structural changes put Medicare on a more solid fiscal footing, more needs to be done to ensure the program is there for future generations.

I note reforms today to reiterate what I have said on several occasions: despite the cries of naysayers, bipartisan Medicare reform is possible, and the passage of MACRA proves that to be the case.

I look forward to continuing the discussion on how to shore up the Medicare program for the long-term, but, for today, let me turn back to the stated purpose of this hearing, which is MACRA's physician payment reforms.

The physician payment reforms are the result of years of effort in the Finance Committee. Working with the House Committees of jurisdiction, this committee was able to craft a legislative solution that garnered the support of nearly every national and State physician organization. This proved to be key to MACRA's enactment as previous efforts to eliminate the SGR had been stymied by the question of what would replace it.

These reforms were intended to accomplish several things. Our most specific goals were to:

- (1) Streamline disjointed incentive programs to reduce the administrative burden on physicians;
- (2) Ensure that metrics on which physicians are assessed are relevant to the patients they treat;
- (3) Provide flexibility to physicians to participate in a way that best fits their practice situation; and
- (4) Provide an incentive to consider and attempt alternative payment models.

We're here today to discuss and hopefully evaluate how CMS has proposed to implement the law in order to achieve these goals.

Let me say that I appreciate the extent to which CMS has reached out to stakeholders to get their thoughts in advance of the proposed rule the agency released in April.

And I understand that CMS continued its outreach during the public comment to ensure that key groups would be informed on the proposal and to hear their reactions. Consultation with stakeholders—especially beneficiaries and physicians on the front lines of providing care—is precisely what we sought when we drafted the statute.

I also appreciate the outreach that CMS has undertaken with Members of Congress and their staff. Viewing implementation as a partnership with Congress is the right way to go.

Without delving too far into my long-standing concerns about the administration's lack of disclosure and cooperation with Congress, I will say that I wish this model would be used more often.

The CMS proposal that resulted from this consultation and outreach is hundreds of pages. And the details matter greatly to our physicians and patients.

This hearing will give CMS a chance to describe its implementation efforts and give members of the committee an opportunity to reflect and ask questions on issues that are garnering significant comment and public discussion. It will also allow members to speak to Congress's intent with regard to MACRA, share insights, and, hopefully, get answers on issues that are important to their constituents.

Before we hear from Mr. Slavitt on CMS implementation though, I want to flag an important concern that I know is shared by others, which is the plight of small and rural physician practices.

We recognized the inherent challenges of these types of practices when we crafted the MACRA statute and I know CMS is aware of these issues, but we need to make sure that the law is implemented in a way that works for these physicians and ensures that these practice settings remain viable options for Medicare beneficiaries.

I look forward to a constructive dialogue here today and to the committee's continued engagement with CMS through the final rule in November and beyond.

PREPARED STATEMENT OF ANDY SLAVITT, ACTING ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Hatch, Ranking Member Wyden, and members of the committee, thank you for the invitation and the opportunity to discuss the Centers for Medicare and Medicaid Services' (CMS's) work to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We greatly appreciate your leadership in passing this important law, which provides a new opportunity for CMS to partner with physicians and clinicians to support quality improvement and develop new payment models to further our nation's shared goals of a health care system that achieves better care, smarter spending, and healthier people and puts empowered and engaged consumers at the center of their care. As we take our initial steps to implement this important law, we have and will continue to work closely with you and listen to the physicians and clinicians providing care to Medicare beneficiaries, with the goal of creating a new payment program that is focused on the needs of patients and responsive to the day-to-day challenges and opportunities within physician practices. As we continue to transform the Medicare program, we are working to move beyond "one size fits all" measurements to an approach that recognizes and supports the diversity of medical practices that serve Medicare beneficiaries and of-

fers multiple paths to value-driven care. To inform this effort, CMS is meeting with practicing physicians across the country, including those in big practices and small practices, specialists and primary care providers, and those in new payment models and in traditional fee-for-service.

CMS is committed to finding ways, to deliver better care at lower costs. Today, over 55 million Americans are covered by Medicare¹—and 10,000 become eligible for Medicare every day.² For most of the past 50 years, Medicare was primarily a fee-for-service payment system that paid health care providers based on the volume of services they delivered. In the last few years, we have made tremendous progress to transform our nation’s health care system into one that works better for everyone and rewards value over volume. Key to this effort is changing how we pay physicians and other clinicians, so they can focus on the quality of care they give, and not the quantity of services they deliver or order. Already, we estimate that 30 percent of traditional Medicare payments are tied to alternative payment models (APMs). Generally speaking, an APM is a model that puts the outcome of the patient at the center and holds care teams accountable for the quality and cost of the care they deliver to a population of patients by providing a financial incentive to coordinate care for their patients. This can help patients receive the clinically appropriate care for their conditions and reduces avoidable hospitalizations, emergency department visits, adverse medication interactions, and other problems caused by inappropriate care or siloed care. Hospital and physician participation in APMs is a major milestone in the continued effort towards improving quality and care coordination. We expect this progress to continue, and we are on track to meet our goal of tying 50 percent of traditional Medicare payments to APMs by 2018—especially in light of MACRA.

The enactment of MACRA, which replaced the Sustainable Growth Rate (SGR) formula with a more consistent way for paying physicians and other clinicians, provided new tools to modernize Medicare and simplify quality programs and payments for these professionals. Currently, Medicare measures the value and quality of care provided by physicians and other clinicians through a patchwork of programs. Some clinicians are part of APMs such as Accountable Care Organizations (ACOs), the Comprehensive Primary Care Initiative, and the Bundled Payments for Care Improvement Initiative—and most participate in programs such as the Physician Quality Reporting System, Physician Value-based Payment Modifier (“Value Modifier Program”), and the Medicare Electronic Health Record (EHR) Incentive Program. Thanks to Congress, MACRA streamlined these various programs into a single framework where clinicians have the opportunity to be paid more for providing better value and better care for their patients. CMS has proposed to implement these changes through the unified framework called the Quality Payment Program.

The Quality Payment Program gives physicians and clinicians the flexibility to participate in one of two paths. First, the Merit-based Incentive Payment System (MIPS) streamlines three existing CMS programs into a single, simplified program with lower reporting burden and new flexibility in the way clinicians are measured on performance. MIPS allows Medicare clinicians to be paid for providing high value care through success in four interrelated performance categories: Quality, Advancing Care Information, Clinical Practice Improvement Activities, and Cost.

For physicians and clinicians who take a further step towards care transformation, the Quality Payment Program rewards physicians and clinicians through a second path, participation in Advanced APMs. Under Advanced APMs, physicians and clinicians would accept more than a nominal amount of risk for providing coordinated, high-quality care for a set portion of their practice, such as through Tracks 2 and 3 of the Medicare Shared Savings Program and the Next Generation ACO model.

Since the enactment of MACRA a little over a year ago, CMS has been developing our approach toward implementation of the new law, and on April 27, 2016, CMS issued a Notice of Proposed Rule Making (NPRM).³ In our efforts to draft a proposal that would be simpler and meaningful for physicians and clinicians, we reached out and listened to over 6,000 stakeholders before we published the proposed rule, including state medical societies, physician groups, consumer groups, and federal part-

¹<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-07-28.html>.

²[http://www.medpac.gov/documents/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-\(june-2015-report\).pdf?sfvrsn=0](http://www.medpac.gov/documents/reports/chapter-2-the-next-generation-of-medicare-beneficiaries-(june-2015-report).pdf?sfvrsn=0).

³<http://federalregister.gov/a/2016-10032>.

ners. We asked for comments⁴ from the stakeholder community on key topics related to how to develop the measurements, scoring, and public reporting for the Quality Payment Program. We conducted multi-day workshops and visited with physicians in their communities individually and in groups to understand how the changes we considered may positively impact care and how to avoid unintended consequences. Just as stakeholder input has been instrumental in the development of the proposed rule, the feedback we have received will be essential in our development of final regulations. Since proposing the rule, CMS has conducted extensive outreach to providers and other stakeholders to ensure that we get their feedback on our proposal. These efforts have stretched across the country and have been both large and small, with more than 200 outreach events. We have also hosted numerous webinars that have seen more than 64,000 participants. We received 3,875 comments during the public comment period.⁵ We are currently reviewing the comments and feedback we received and expect to issue final rulemaking after this review is complete.

The input we have received from stakeholders throughout the process has been very valuable: physicians and clinicians want support for a care system that focuses on quality, but too many unaligned quality programs, measures, and technology requirements can hinder their best efforts to accomplish these goals. Based on what we learned, our approach to implementation has been guided by four principles. First, patients are, and must remain, the key focus. Financial incentives should work in the background to support physician and clinician efforts to provide high quality services, and the needs of the patient, not measurements, need to be the focus of our approach. Second, success will come from adopting approaches that can be driven by the physician practice. Quality measurement needs to accurately reflect the needs of a diverse range of patient populations and practice types and give physicians and other clinicians the opportunity to select elements of the program and measures that are right for their practice. Third, in everything we do, we must strive to make care delivery as simple as possible, with more support for collaboration and communication through delivery system reform. Fourth and finally, we must focus on the unique concerns of small independent practices, as well as rural practices and practices in underserved areas.

We relied heavily on stakeholder input we received over the last year to inform our proposal of a scoring methodology for MIPS that aims to improve upon and streamline existing measures in the quality, cost, and advancing care information categories, which are based in part upon current CMS programs. In particular, we have been working side-by-side with the physician and consumer communities to address needs and concerns about the Medicare EHR Incentive Program, often known as Meaningful Use for physicians, as we transition it to the Advancing Care Information category in MIPS. The new approach heightens focus on the patient, increases flexibility, reduces burden, and concentrates on aspects of health information technology, such as health information exchange, that are critical for delivery system reform and improving patient outcomes. We also used this feedback when proposing the new clinical practice improvement activities category, which the statute created. When developing the proposed activities for this category, we listened closely to specialty societies and associations when creating options to allow clinicians to select activities that match their practices' goals.

While we expect that most clinicians will participate in MIPS for the first years of the Quality Payment Program, we will continuously search for opportunities to expand and refine our portfolio of payment models in order to maximize the number of physicians and other clinicians who have the opportunity to participate in Advanced APMs. It is our intent to allow as much flexibility as possible for clinicians to switch between MIPS and participation in Advanced APMs based on what works best for them and their patients. The proposed rule is the latest step in our efforts to work in concert with stakeholders on the front-line of care delivery to draw upon their expertise and incorporate their input into the policies for the Quality Payment Program so that together, we can achieve the aim of the law.

NOTICE OF PROPOSED RULE MAKING (NPRM)

In our proposed rule, we provide details and descriptions of the proposed policies that will allow us to implement the important new provider payment provisions included in MACRA.

⁴<http://federalregister.gov/a/2015-24906>.

⁵<https://www.regulations.gov/document?D=CMS-2016-0060-0068>.

Merit-based Incentive Payment System (MIPS)

Currently, Medicare measures physicians and other clinicians on how they provide quality care and reduce costs through a patchwork of programs, with clinicians reporting through some combination of the Physician Quality Reporting System, the Value Modifier Program, and the Medicare EHR Incentive Program. Through the law, Congress streamlined and improved these reporting programs into the Merit-based Incentive Payment System. Under MIPS, eligible physicians and clinicians will report their performance under four categories and will receive a payment adjustment based on their overall performance, or composite performance score.

Consistent with the goals of the law, the proposed rule would improve the relevance of Medicare's value and quality-based payments and increase clinician flexibility by allowing clinicians to choose measures and activities appropriate to the type of care they provide. Under our proposed rule, performance measurement under the new program for physicians and other eligible clinicians would begin in 2017, with payments based on those measures beginning in 2019. MIPS allows Medicare clinicians to be paid for providing high quality, efficient care through success in four performance categories:

1. **Quality (50 percent of total score in year 1; replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program):** Clinicians would choose to report six measures versus the nine measures currently required under the Physician Quality Reporting System. This category gives clinicians reporting options to choose from to accommodate differences in specialty and practices.
2. **Advancing Care Information (25 percent of total score in year 1; replaces the Medicare EHR Incentive Program for physicians, also known as "Meaningful Use"):** Clinicians would choose to report customizable measures that reflect how they use health information technology in their day-to-day practice, with a particular emphasis on interoperability and secure information exchange. Unlike the existing Meaningful Use program, this category would not require quality reporting, which would be assessed within the Quality category.
3. **Clinical Practice Improvement Activities (15 percent of total score in year 1):** Clinicians would be rewarded for clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety. Clinicians may select activities that match their practices' goals from a list of more than 90 options. In addition, clinicians would receive credit in this category for participating in APMs and in Patient-Centered Medical Homes.
4. **Cost (10 percent of total score in year 1; replaces the cost component of the Value Modifier Program, also known as Resource Use):** The score would be based on Medicare claims and require no reporting by physicians or other clinicians. This category would integrate more than 40 episode-specific measures to account for differences among specialties.

The law requires MIPS to be budget neutral. Therefore, physicians' and clinicians' MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare Part B payments. In the first year, depending on the variation of MIPS scores, adjustments are calculated so that negative adjustments can be no more than 4 percent, and positive adjustments are generally up to 4 percent; the positive adjustments will be scaled up or down to achieve budget neutrality. Also, in the first 6 years of the program, additional bonuses are provided for exceptional performance.

Advanced Alternative Payment Models (APMs)

For clinicians who take a further step towards care transformation, the law creates another path. Physicians and clinicians who participate to a sufficient extent in Advanced APMs would qualify for incentive payments. Importantly, the law does not change how any particular APM rewards value. Instead, it creates extra incentives for participation in Advanced APMs. For years 2019 through 2024, a physician or clinician who meets the law's standards for Advanced APM participation in a given year is excluded from MIPS payment adjustments and receives a 5 percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher annual fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

Under the law, Advanced APMs are those in which clinicians accept risk and reward for providing coordinated, high-quality, and efficient care. As proposed, Advanced APMs must generally:

1. **Require participants to bear a certain amount of financial risk.** Under our proposal, an Advanced APM would meet the financial risk requirement if CMS would withhold payment, reduce rates, or require the entity to make payments to CMS if its actual expenditures exceed expected expenditures, consistent with parameters we specified in the rule.
2. **Base payments on quality measures comparable to those used in the MIPS quality performance category.** To meet this statutory requirement, we propose that an Advanced APM must base payment on quality measures that are evidence-based, reliable, and valid. In addition, at least one such measure must be an outcome measure if an outcome measure appropriate to the Advanced APM is available on the MIPS measure list.
3. **Require participants to use certified EHR technology.** To meet this requirement, we propose that an Advanced APM must require that at least 50 percent of the clinicians use certified EHR technology to document and communicate clinical care information in the first performance year. This requirement increases to 75 percent in the second performance year.

In addition, under the statute, medical home models, which are a popular and patient-centered approach for primary care practices to coordinate care, that have been expanded under the Innovation Center authority qualify as Advanced APMs regardless of whether they meet the financial risk criteria. While medical home models have not yet been expanded, the proposed rule lays out criteria for medical home models to ensure that primary care physicians have opportunities to participate in Advanced APMs.

The rule proposes a definition of medical home models, which focus on primary care and accountability for empaneled patients across the continuum of care. Because medical homes tend to have less experience with financial risk than larger organizations and limited capability to sustain substantial losses, we propose unique Advanced APM financial risk standards, consistent with the statute, to accommodate medical homes that are part of organizations with 50 or fewer clinicians.

The proposed rule includes a list of models that would qualify under the terms of the proposed rule as Advanced APMs. These include:

- Comprehensive ESRD Care (Large Dialysis Organization arrangement);
- Comprehensive Primary Care Plus (CPC+);
- Medicare Shared Savings Program—Track 2;
- Medicare Shared Savings Program—Track 3;
- Next Generation ACO Model; and
- Oncology Care Model—Two-sided risk (available in 2018).

Under the proposed rule, CMS would update this list annually to add new payment models that qualify. CMS will continue to modify models in coming years to help them qualify as Advanced APMs. In addition, starting in performance year 2019, clinicians could qualify for incentive payments based in part on participation in Advanced APMs developed by non-Medicare payers, such as private insurers, Medicare Advantage plans, or State Medicaid programs.

We recognize the substantial time and money commitments in which APM participants invest in order to become successful participants. Under the proposed rule, physicians and clinicians who participate in Advanced APMs but do not meet the law's criteria for sufficient participation in Advanced APMs, and those who participate in certain non-Advanced APMs, would be exempt from the Cost category in MIPS, would be able to use their APM quality reporting for the MIPS Quality category, and would receive credit toward their score in the Clinical Practice Improvement Activities category. We want to make sure that in addition to encouraging physicians and other clinicians to improve quality of care by participating in APMs that best fit their practice and patient needs, physicians and clinicians are not subject to duplicative, overly burdensome reporting requirements.

PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

To help spur innovation for models that meet the needs of the physician community, MACRA established a new independent advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC will meet at least quarterly to review physician-focused payment models submitted by individuals and stakeholder entities and prepare comments and recommendations on proposals that are received, explaining whether models meet CMS criteria for physician-focused payment models. The 11 members of the PTAC, who were appointed by the Comptroller General, are experts in physician-focused payment models and related delivery of care, including researchers, practicing physicians, and other stakeholders. The PTAC has met twice and presentations from the meeting are available online.⁶ We encourage physician specialists and other stakeholders to engage with the PTAC to suggest well designed, robust models. CMS is committed to working closely with the PTAC and are looking forward to reviewing their recommendations for new physician-focused payment models.

TECHNICAL ASSISTANCE

We know that physicians and other clinicians may need assistance in transitioning to the MIPS, and we want to make sure that they have the tools they need to succeed in a redesigned system. Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs).

Last month, CMS announced the availability of \$20 million of this funding for on-the-ground training and education for Medicare clinicians in individual or small group practices of 15 clinicians or fewer. These funds will help provide hands-on training tailored to small practices, especially those that practice in historically under-resourced areas including rural areas, HPSAs, and medically underserved areas. As required by MACRA, HHS will award \$20 million each year for 5 years, providing \$100 million in total to help these practices successfully participate in the Quality Payment Program.

In addition to MACRA implementation efforts, last month, CMS launched the second round of the Support and Alignment Networks under the Transforming Clinical Practice Initiative. This opportunity will provide up to \$10 million over the next 3 years to leverage primary and specialist care transformation work and learning that will catalyze the adoption of APMs on a large scale. Support and Alignment Network 2.0 awardees' activities, coaching, and technical assistance will help practices transform the way they deliver care. The ultimate goal is for these practices to participate in APMs and Advanced APMs. Critical to this approach is the capacity for awardees to accurately identify large numbers of clinicians and practices in advanced states of readiness through sound data analytics capabilities, to enroll them into the Transforming Clinical Practice Initiative, to provide them with tailored technical assistance, and to align them with the most suitable Alternative Payment Model options. Further, awardees will need to customize direct technical assistance and support services that are tailored to these clinicians' and practices' needs.

CONCLUSION

MACRA will help move Medicare towards more fully rewarding the value and quality of services provided by physicians and other clinicians, not just the quantity of such services. For it to be successful—in other words, for MACRA to improve care delivery and lower health care costs—we must first demonstrate to clinicians and patients both the value of these new payment programs established by MACRA and the opportunity for these participants to shape the health care system of the future. The program must be flexible, practice-driven, and person-centered. It must contain achievable measures; it must support continued and improved information sharing through innovations and advancements in interoperability and the health IT infrastructure; it must engage and educate physicians and other clinicians; and it must promote and reward improvement over time.

Our proposed rule incorporates valuable input received to date, but it is only a first step in an iterative process for implementing the new law. Moving forward, we will continue to gather feedback from our stakeholders, to inform an implementation approach that leads to better care, smarter spending, and improved patient outcomes. We will continue partnering with Congress, physicians and other providers,

⁶<https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee>.

consumers, and other stakeholders across the Nation to make a transformed and improved health system a reality for all Americans. We look forward to working with you as we continue to implement this seminal law.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

There are big opportunities ahead to make substantial, bipartisan progress when it comes to protecting and updating the Medicare guarantee, and that's what the committee will be discussing this morning.

The first is implementing the plan to throw in the trash can the hopelessly broken, out-of-date Medicare reimbursement formula known as the SGR. This was the source of endless uncertainty for health-care providers and seniors, and it's now in the dustbin of history. Today, the committee will talk about how its replacement will be implemented.

Second, it's important to build on the new Medicare payment system, and in my view the obvious place to start ought to be in the area of chronic care. Seniors suffering from these chronic illnesses, such as heart disease, cancer, diabetes and stroke, now account for 93 percent of spending in the program. I'm glad that's now a bipartisan focus of this committee.

By finally clearing the decks of the SGR debacle, the Finance Committee has been able to get to work on developing legislation that will empower families and Medicare to manage and treat these debilitating diseases. I'd like to thank Chairman Hatch, along with Senators Isakson and Warner especially, for their continued dedication to this issue. This effort is already paying dividends; last week, in a rule released by the Centers for Medicare and Medicaid Services (CMS), they proposed adopting four policies the chronic care group has developed and putting them in place administratively. There's still more work to be done, but that was a promising start.

Now when it comes to replacing the SGR, Medicare payment reform took the important step of engraving in stone the principle of rewarding medical care that provides quality over quantity. For the seniors who depend on the Medicare guarantee, that ought to result in better, more thoughtful health care. That's the direction that healthcare is headed in across the country, and Medicare should be leading the way.

I'll make two key points about what it's going to take to implement this legislation the right way.

First is to make sure all doctors who care for our seniors get fair treatment under these new rules. That's particularly important for the small or solo practitioners who are truly the backbone of rural communities.

Second, this legislation supports efforts to strengthen primary care, which in my view is key to making people healthier and bringing down costs. For example, the "Comprehensive Primary Care Plus" model allows Medicare to partner with commercial and State health insurance plans so everyone is on the same page when it comes to paying for value and quality care.

That means a primary care doctor who has business in the commercial market and in Medicare doesn't have to find a balance between many different sets of rules as she's trying to serve as many people in her community as possible. This is just one promising example, if done right, of innovative changes to the way doctors are paid that will improve care for seniors in the program—exactly what these reforms were designed to do.

I'd also like to thank Andy Slavitt, Acting Administrator of the Centers for Medicare and Medicaid Services, for joining the committee this morning. Andy has always been committed to doing right by the millions of Americans who have to navigate the health-care system every day. His role in pushing for more value and quality in healthcare is a big part of making that a reality.

COMMUNICATIONS

ALLIANCE OF SPECIALTY MEDICINE
3823 Fordham Road, NW
Washington, DC 20016

Chairman Hatch, Ranking Member Wyden, and members of the committee, the Alliance of Specialty Medicine (the Alliance) would like to thank the Senate Committee on Finance for the opportunity to provide feedback on implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Alliance strongly supports your involvement in ensuring that the Centers for Medicare and Medicaid Services (CMS) follows the legislative intent of MACRA as CMS undergoes rulemaking to implement its provisions. The Alliance is a coalition of medical specialty societies representing more than 100,000 physicians and surgeons from specialty and subspecialty societies dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care.

Member organizations of the Alliance have continuously sought out and developed robust mechanisms (including clinical decision support, clinical data registries, and other tools) aimed at improving the quality and efficiency of care specialty physicians provide. In addition, Alliance member organizations have analyzed and heavily scrutinized data related to the services they provide, looking for ways to improve how they diagnose, treat, and manage some of the most complex health care conditions in their respective specialty areas. With those sentiments in mind, the Alliance is eager to engage in programs that would further these efforts with incentives and technical assistance.

However, despite the considerable and often overwhelming effort the Alliance put into helping shape provisions in the MACRA legislation, as well as the ongoing feedback provided during the many pre-rulemaking comment and feedback opportunities, we are concerned that several of the principles we have long supported and conveyed to the agency were largely ignored. This is particularly true when it comes to proposals associated with the use of electronic health records (EHRs), the application of socioeconomic risk factors in quality and cost metrics, and most importantly, substantial disparities in Quality Payment Program (QPP) requirements that significantly disadvantage specialty care providers and the patient populations they serve. We hope that our comments herein will move CMS to address some of the most pressing issues facing specialty medicine, removing barriers that limit meaningful specialty physician engagement, and offering all specialists and non-specialists equal opportunities to demonstrate quality in a relevant manner.

Our written testimony below will detail some concerns regarding the proposals in the CMS proposed rule titled “Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models.”

As discussed in more detail below, the Alliance has the following recommendations:

- CMS should modify the initial start date of MIPS so physicians and practices have adequate time to prepare for the new program. MIPS should start no earlier than July 1, 2017, allowing CMS to establish a shorter performance period in the first year of the QPP program—such as a 6-month performance period, with an optional “look-back” to January 1 in 2017.
- CMS should minimize the reporting burden, particularly during the initial transition period, by maintaining the current PQRS reporting thresholds. Additionally, CMS should retain measures groups.
- The cost and resource use measures are completely flawed and inadequate. As such, CMS should use its authority under MACRA to re-weight this category to zero.

- There are very few activities that create a pathway for specialists to earn credit for their engagement in clinical practice improvement activities, and it is essential that CMS expand its list of recognized activities for this MIPS category.
- CMS should eliminate the “all or nothing” scoring in the electronic health record (now known as “advancing care information”) category.
- The proposed QPP largely retains the flawed siloed approach of Medicare’s current quality improvement programs and its scoring system is extremely complex. CMS should, therefore, rethink its scoring methodology and make modifications that would standardize, streamline, and maintain consistency so that MIPS eligible clinicians are able to understand and respond appropriately.
- We continue to be frustrated by the lack of APM participation options available to specialty physicians.
- CMS must establish a mechanism for distinguishing subspecialties to ensure that smaller subspecialties are not disadvantaged by the QPP and its scoring methodology.

Proposals for the Merit-Based Incentive Payment System (MIPS)

The MIPS Performance Period

Given the breadth of proposed changes to CMS’s quality and performance improvement programs, we are very concerned about the timeframe in which the agency expects to begin evaluating specialty physician performance. We are sympathetic to the administrative challenges CMS faces in operationalizing the new program. However, Alliance member organizations are concerned that specialty physicians will not be able to successfully adapt under the proposed rigorous schedule.

Even before MACRA was signed into law, specialty societies were educating their members on the anticipated changes. Unfortunately, and not unlike with other CMS programs, the challenge of educating physicians on these new programs has been difficult. We find that many of our specialty society staff are still educating members on CMS’s long-standing quality programs, including the Physician Quality Reporting System (PQRS) and Value-Based Payment Modifier (VM)/Physician Feedback Program. As you know, PQRS continues to have relatively low participation rates, and those facing adjustments under the VM do not understand exactly from where those penalties stem. As a significant portion of the MIPS is based on the PQRS, which continues to suffer from critical measure gaps in regards to specialty medicine, as well as the flawed VM and problematic Quality and Resource Use Reports (QRURs) distributed under the Physician Feedback Program, we are deeply concerned about the impact this will have on specialty physicians.

As most specialty physicians will not be ready on January 1, 2017 to begin MIPS, CMS should modify the initial start date of the MIPS program and provide a shorter reporting/performance period in 2017—*e.g.*, 6 months, with an optional “look-back” to January 1 in 2017. CMS should maintain this shorter reporting/performance period in future years of the program (with an optional “look-back” to January 1), in addition to any year-long reporting requirements, beginning in 2018. This shorter reporting/performance period will provide a necessary “on-ramp” for many specialty physicians who will be new to the program. And, it is consistent with approaches CMS has taken previously with the Medicare EHR Incentive Program, which currently utilizes a 90-day reporting period.

The MIPS Quality Performance Category

For the quality performance category, CMS proposes to adopt requirements similar to those under the existing Physician Quality Reporting System (PQRS). We are concerned with this approach, because, as you know, PQRS continues to have relatively low participation rates, and it has been difficult educating our members on the complexities of the PQRS. Furthermore, some of CMS’s proposals under the quality performance category would make it more difficult for specialty providers to be successful under the MIPS. Specifically:

- **The Removal of Measures Groups:** CMS proposes to no longer include Measures Groups as a data submission method for purposes of the quality performance category. In its place, CMS is proposing specialty-specific measure sets, which CMS believes will address confusion in the quality measure selection process. Some of the specialties represented in the Alliance heavily rely on Measures Groups to meet quality reporting requirements under the current PQRS program and would appreciate the opportunity to continue meeting the quality reporting requirements under the quality performance category in the same way. By proposing to do away with this reporting mechanism, CMS is severely limiting meaningful quality reporting options available to many special-

ists, particularly those in small practices. Similarly, in many instances, the proposed removal of measure groups will either leave no *meaningful* measures for certain specialties and subspecialties or greatly diminish the value of the measures that CMS proposes to retain as stand-alone measures.

- **Increasing the Data Completeness Threshold:** CMS also proposes to revise its data completeness thresholds such that individual MIPS eligible clinicians submitting via Part B claims would need to report on 80 percent of his/her Medicare Part B-only patients; whereas individual MIPS eligible clinicians and groups submitting via Qualified Clinical Data Registry (QCDR), qualified registry, and EHR would need to report on 90 percent of their Medicare and non-Medicare patients. We very much oppose this proposal and request that CMS lower the reporting thresholds for all reporting mechanisms to 50 percent, which is consistent with the current PQRS reporting requirements. As an alternative, CMS could consider simply requiring reporting on 20 consecutive patients, which would be consistent with CMS' current threshold for Measures Groups under the PQRS program.

The MIPS Resource Use Performance Category

We are deeply concerned about the use of the VM measures in the MIPS program, particularly in the initial years. A CMS report on the result of the 2016 VM program (based on 2014 performance) showed that only 128 groups exceeded the program's benchmarks in quality and cost efficiency and earned a 2016 payment incentive. In contrast, physicians in 5,418 groups that failed to meet minimum reporting requirements saw a "–2.0%" decrease in their Medicare payments in 2016 and physicians in 59 groups saw a decrease in their Medicare payments based on their performance on cost and quality measures under the VM. The disparity in groups earning an incentive or receiving a negative adjustment for the 2016 VM is great. It is clear these measures are not ready for prime time, and the need to further refine and evaluate episode-based cost measures is essential.

Furthermore, in calculating the performance under the resource use performance category, CMS proposes to include several clinical condition and treatment episode-based measures that have been reported in Supplemental Quality and Resource Use Reports (sQRURs) or were included in the list of the episode groups developed under section 1848(n)(9)(A) of the Act published on the CMS website. We are concerned about the premature application of these cost measures, which have not been adequately vetted by specialty care providers given their limited use. Most of the cost measures are new, only recently having been put forward for comment as part of CMS's Episode Groups Request for Comment. The remaining measures may have been included in sQRURs, however, very few clinicians understood (or understand) how to access or interpret their QRURs or sQRURs.

For these reasons, we strongly urge CMS to use its authority under MACRA to re-weight this category to zero.

The MIPS Clinical Practice Improvement Activity (CPIA) Category

Despite the inclusion of 94 unique activities in the Clinical Practice Improvement Activity (CPIA) inventory, the vast majority of activities are focused on activities more appropriate for primary care providers. There are very few activities that create a pathway for specialists to earn credit for their engagement in clinical practice improvement. The list of proposed CPIAs neither includes the vast majority of activities we suggested for inclusion nor did CMS acknowledge that it had at least considered these activities for inclusion. We urge CMS to reconsider including these activities in the proposed rule. They include:

- Attendance and participation in Accreditation Council for Continuing Medical Education (ACCME)-accredited continuing medical education (CME) and non-CME events, such as the specialty and subspecialty society conferences and events, including those that are web-based, that exceed certification requirements;
- Fellowship training or other advanced clinical training completed during a performance year;
- Participation in morbidity and mortality (M&M) conferences;
- Taking emergency department (ED) call as part of Expanded Practice Access,
- Voluntary practice accreditation, such as accreditation achieved by the National Committee on Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAAHC), The Joint Commission (TJC), or other recognized accreditation organizations;

- Demonstration of incorporation of evidence-based practices and appropriate use in clinician practices, using evidence-based clinical guidelines, appropriate use criteria, “Choosing Wisely” recommendations, etc.;
- Engagement in state and local health improvement activities, such as participation in a regional health information exchange or health information organization;
- Engagement in private quality improvement initiatives, such as those sponsored by health plans, health insurers, and health systems; and
- Participation in other federally sponsored quality reporting and improvement programs not already affiliated or considered under the MIPS program.

CMS intends, in future performance years, to begin measuring CPIA data points for all eligible clinicians and to award scores based on performance and improvement. We strongly oppose this proposal, particularly given there are no baseline or benchmark data available for comparison. In addition, we believe that requiring this diverts from the Congressional intent of including this proposal in the first place.

The MIPS Advancing Care Information Performance Category

We are sorely disappointed in the proposals included in the Advancing Care Information performance category. The implementation of programs established under MACRA afforded CMS a unique opportunity to drastically change the direction of the meaningful use program for physicians. Since the fall, CMS promised a more flexible program in response to physician concerns heard around the country. Instead, the measures that CMS has retained are every bit the same and even more difficult with the proposed removal of most exclusions. Under CMS’s base scoring proposals, they must still report on at least one patient for each of the measures in the objectives that require reporting a numerator/denominator. MIPS eligible clinicians will continue to be forced to report on measures that are not meaningful to their practice and patient populations. While CMS touts these modifications as a departure from the previous “all-or-nothing” approach to the Medicare EHR Incentive Program, specialty physicians observe little change in how they can approach the new requirements and be successful.

The MIPS Composite Performance Score Methodology

We are deeply concerned about the scoring methodology for MIPS. Alliance member organizations have reviewed the proposals in great detail, yet we continue to find the proposals extremely complex and confusing. We recognize that, to provide flexibility, the scoring will be more difficult. However, if our most sophisticated and knowledgeable volunteer physician leaders are struggling to understand the scoring proposals, how does CMS expect the vast majority of physicians in practice to understand?

The proposed methodology also maintains the current silos of performance scoring, despite the fact that scoring is all rolled up into a composite performance score. To move toward a more value-driven health care system, it seems that the scoring should provide physicians with meaningful and actionable information that leads them toward that goal.

We request that CMS rethink its scoring methodology and make modifications that would standardize, streamline, and maintain consistency so that MIPS eligible clinicians are able to understand and respond appropriately.

Alternative Payment Models (APMs)

Specialty physicians are at a disadvantage as the proposed Advanced Alternative Payment Models (APMs) remain primary care-focused, leaving specialty physicians with few APM participation options. Despite its Request for Information (RFI) on Specialty Practitioner Payment Model, the Center for Medicare and Medicaid Innovation (CMMI) has not made a concerted effort to ensure specialists have a pathway toward engaging in APMs. Only two models currently cover specialty medicine—the Oncology Care Model and the Comprehensive Care for Joint Replacement Model, the latter of which CMS did not propose to qualify as an Advanced APM.

We continue to be frustrated by the lack of APM participation options available to specialty physicians given the intent of MACRA to move physicians away from traditional fee-for-service and into payment models that better focus on cost and quality. We urge CMS to offer guidance on how APMs that did not meet the proposed Advanced APM criteria could be altered to meet the criteria. It seems as if in many cases, it is simply a lack of quality metrics or concerted use of certified electronic health record technology (CEHRT) that limit those models from Advanced APM status. If that is the case, we request that CMS work with the developers and partici-

pants of those models to make modifications that lead to Advanced APM designation.

Distinguishing Specialty Care Physicians

Finally, member organizations in the Alliance represent a broad array of specialty and subspecialty organizations. However, CMS' current proposals do not recognize the intricacies of all of these specialties and subspecialties. For example, Mohs micrographic surgeons are identified in claims and other datasets as relatively low-quality and/or high-cost providers because they are being compared to the whole of dermatology. Mohs surgeons focus their practice on skin cancer diagnosis and treatment, unlike a lot of other dermatologists who may be focused on other conditions, such as acne.

Individually, many of these subspecialty providers have urged CMS to use "Level III, Area of Specialization" codes from the Healthcare Provider Taxonomy code set to develop quality and cost benchmarks for these providers to at least somewhat level the playing field. We request that CMS begin the process for developing appropriate benchmarks for these providers using the aforementioned "third-tier" taxonomy codes. Without being able to more accurately define the role of a provider, it would be difficult for CMS to truly measure performance.

Thank you again for taking into consideration our written comments. The Alliance of Specialty Medicine looks forward to working with the committee on addressing these issues to ensure the successful implementation of MACRA and we would be happy to discuss our concerns with you, as well as any other questions you may have going forward.

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Statement for the Record

The American College of Physicians (ACP) applauds Chairman Hatch and Ranking Member Wyden for holding this hearing on the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). The College appreciates the opportunity to provide a statement to the Senate Finance Committee that includes our recommendations to improve the implementation of MACRA. These recommendations are based on a comment letter that ACP sent last month to the Centers for Medicare and Medicaid Services (CMS) Acting Administrator Andy Slavitt that provides our ideas for improvements to the proposed rule that was released earlier this year by CMS to implement MACRA.

ACP has developed three principles that Congress should use to ensure that this law is implemented in a manner that truly improves care for Medicare beneficiaries and thus the policy that is developed to guide these new value based payment programs must be thoughtfully considered in that context. We believe that these principles are also consistent with the manner that Congress intended the law to be implemented. These principles are:

- **That the new payment systems should reflect the lessons from current and past programs and effectively allow for ongoing innovation and learning. The agency must constantly monitor the evolving measurement system to identify and mitigate any potential unintended consequences.**
- **CMS should work to ensure that patients, families, and their relationships with their physicians are at the forefront of thinking in developing the new payment systems.**
- **CMS should collaborate with specialty societies, frontline clinicians, and Electronic Health Records (EHRs) vendors in the development, testing, and implementation of measures with a focus on integrating the measurement of and reporting on performance with quality improvement and care delivery and decreasing clinician burden.**

We ask Congress to not only use these principles to guide the oversight process, but also offer a series of concrete recommendations to CMS that we believe will help ensure that the law is implemented in a manner that serves the interests of our patients and also follows Congressional intent. We look forward to working with

Congress to ensure that these recommendations are implemented as our physicians prepare to move toward a new value-based payment system.

Among the detailed suggestions, we have outlined a set of top priority tasks for CMS, including the following:

- **Implement an alternative Merit-Based Incentive Payment System (MIPS) scoring methodology, developed by ACP, which combines, simplifies, aligns, and reduces the complexity of the four reporting categories.**
- **Provide better opportunities for small practices to succeed, including via the creation of virtual groups for assessment under MIPS, while holding practices of nine or fewer eligible clinicians harmless from any potential downward adjustments until such time that a virtual groups option is made available.**
- **Make significant improvements to simplify, harmonize and reduce the burden of quality measurement and reporting for MIPS both over the short and longer term.**
- **Simplify reporting requirements within CMS's Advancing Care Information (ACI) program that is to replace the current Meaningful Use program.**
- **Change the start date for the First Performance Year in the Quality Payment Program (QPP) to July 1, 2017.**
- **Improve the opportunities for Patient-Centered Medical Homes (PCMHs) and PCMH Specialty Practices in MIPS and for PCMHs as advanced Alternative Payment Models (APMs).**
- **Implement changes that would make more advanced APMs available for physicians in all specialties, especially including those in internal medicine and its subspecialties.**

At this time, we believe that CMS is sincerely open to making improvements from its proposed rule, and do not believe that it is necessary or desirable for Congress to make any legislative changes to MACRA. Rather, we encourage the Senate Finance Committee, and the House Medicare committees of jurisdiction, to exercise oversight over CMS's implementation, and specifically, to be supportive of the following recommendations in ACP's comment letter on the NPRM.

Implement an Alternative Scoring Methodology for MIPS

ACP recommends that CMS simplify and clarify performance scoring in the final rule to allow physicians to better assess the scoring and weighting within each category. The scoring approach included in the proposed rule had different points systems and scales for each of the four reporting categories, making it unnecessarily complicated; ACP's alternative would put the points all on the same scale, combining them into one simplified and harmonized program as Congress intended.

ACP proposed to CMS a more simplified alternative that would make all available points within the quality component add up to a total of 50 points, not 80—which then counts for 50 percent; the points within resource use would add up to a total of 10 or less; the points within Clinical Practice Improvement Activities (CPIA) would add up to 15; and the points within ACI would add up to 25 (and not 131, with only 100 of those points actually “counting,” as currently proposed).

By simplifying the scoring to allow the maximum points for each measure or activity to directly translate to its contribution to the overall CPS, the scoring will be streamlined to better account for MIPS as one comprehensive program rather than silos for each performance category. This will allow physicians to better focus their efforts on the activities and measures that are most meaningful to their patients and practice.

Provide Better Opportunities for Small Practices to Succeed

Section 1848(q)(5)(I) of the Act establishes the use of voluntary virtual groups for certain assessment purposes. The statute requires the establishment and implementation of a process that allows an individual MIPS eligible clinician (EC) or a group consisting of not more than 10 MIPS ECs to elect to form a virtual group with at least one other such individual MIPS EC or group of not more than 10 MIPS ECs for a performance period of a year. While the rule recognizes this requirement, it proposes to delay the onset of this provision until the 2018 performance year based

on identified significant barriers regarding the development of a technological infrastructure required for successful implementation and the operationalization of provisions that would make this a conducive option for MIPS ECs or groups.

The College believes that the implementation of the virtual groups' provision is an important step towards establishing a viable and effective quality payment program. It will allow small practice clinicians to aggregate their data to allow for more reliable and valid measurement as well as serve as a platform to facilitate shared accountability and collaborative efforts. While we recognize and appreciate the barriers mentioned towards implementation in time for the 2017 performance period, ACP is not supportive of the planned delay in implementation. It places small practices in a situation in which payment adjustments based upon the 2017 performance year will likely be based upon suspect data.

Therefore, ACP strongly urges CMS to include in the final rule for the 2017 performance period a policy that allows small practices to join together as virtual groups for the purposes of MIPS assessment in the initial performance period. This is a critical option that small practices should be permitted in order to allow greater assessment opportunities under MIPS. To accomplish creating a virtual group option for the first performance period, the College notes that CMS can utilize Interim Final Rulemaking processes.

If the Agency is unable to provide a virtual group option through rule-making for the first year, then as a backup, ACP recommends that CMS treat small practices in a manner similar to how they were treated in the phase-in of the Value-based Payment Modifier (VBM) program. Under this option, CMS would allow solo clinicians and groups of 2-9 ECs who report under MIPS to be held harmless from any potential downward adjustments until such time that a virtual groups option is made available. They should still be eligible for upward adjustments.

Make Significant Improvements to Quality Measurement and Quality Reporting for MIPS and Over the Longer Term

In our comments on the quality component of MIPS, it seems imperative to reiterate our call for CMS to use the opportunity provided through the new MACRA law to actively build a learning health and healthcare system. It is critically important that the new payment systems that are designed through the implementation of MACRA reflect the lessons from the current and past programs and also effectively allow for ongoing innovation and learning. Overall, quality measurement must move toward becoming more relevant and accurate, and toward effective approaches of measuring patient outcomes.

We provide these specific recommendations for CMS to properly implement the new Quality Performance Category:

- 1. The College recommends that CMS collaborate with specialty societies, frontline clinicians, and EHR vendors in the development, testing, and implementation of measures with a focus on integrating the measurement of and reporting on performance with quality improvement and care delivery and on decreasing clinician burden.**

It is critically important to constantly monitor the evolving measurement system to identify and mitigate any potential unintended consequences, such as increasing clinician burden and burn-out, adversely impacting underserved populations and the clinicians who care for them, and diverting attention disproportionately toward the things being measured to the neglect of other critically important areas that cannot be directly measured (*e.g.*, empathy, humanity).

- 2. We recommend that ideally any measures CMS proposes to use outside of the core set identified by the Core Quality Measures Collaborative be endorsed by the Measure Application partnership.**

ACP is appreciative that CMS has proposed to reduce the overall number of measures required for reporting from nine measures to six, as well as removing the requirement that these measures fall across all of the National Quality Strategy domains. However, the College would like to reiterate our overall concerns with the performance measures that are currently in use within the Physician Quality Reporting System (PQRS) program, as well as many of those proposed for use within MIPS. To begin to address this issue in the short term, in our comments on the draft Measurement Development Plan (MOP), ACP called on CMS to utilize the core set of quality measures identified by the Core Quality Measures Collaborative.

3. CMS should consider the recommendations made by ACP’s Performance Measurement Committee with regard to measure selection within MIPS.

These recommendations, as listed on the ACP website (with a thumbs up, down, or sideways), are based upon a scientific review process that involves four domains: purpose and importance to measure, clinical evidence base, measure specifications, and measure implementation and applicability.

4. CMS should take concrete actions to provide clear options for those specialties and subspecialties that may be most impacted by too few appropriate measures.

Many of these specialties may already be impacted under the current proposal—particularly by a lack of outcomes and/or high priority measures—and certainly would be affected if a number of the measures available were to be reduced through a more focused and needed approach of ensuring measure validity, clinical relevance, and ability to implement. These actions should include:

- Developing a process to determine, in advance of the reporting year, which quality measures are likely applicable to each EC—and only holding them accountable for these relevant measures (*i.e.*, weighting performance on the remaining measures higher, rather than penalizing them with a score of zero on unreported measures).
- Putting a process in place, for the short term, to address the significant issues of validity and ability to implement associated with using measures that are not endorsed by the National Quality Forum (NQF), and/or ACP recommended.
- Establishing safe harbors for entities that are taking on innovative approaches to quality measurement and improvement and also provide clear protections for individual clinicians who participate in these types of activities—this could be done by having the entities register certain measures as “test measures.”
- Ensuring that the flexibility for Qualified Clinical Data Registries (QCDRs) to develop and maintain measures outside of the CMS selection process is protected.

Simplify Reporting Requirements for the ACI Program

ACP proposed significant improvements to simplify the reporting requirements for the ACI program that is to replace Meaningful Use in the new law. ACP has been a consistent advocate of physicians and other clinicians leveraging EHRs and other health information technology (IT) to improve care. As such, ACP was a strong supporter of the goals of the HI-TECH Act and of the Meaningful Use program, although we have expressed concerns regarding the implementation of the Meaningful Use program, specifically due to the uniform (or one-size-fits-all) and overly prescriptive approach taken by CMS, which turned what should have been an incentive program towards specialty-specific optimization of the emerging health IT infrastructure into a “check the box” compliance exercise. That said, the ACP believed that the Meaningful Use program accomplished many of its objectives, and with the coming of Medicare’s QPP via MACRA, CMS had a golden opportunity to fix Meaningful Use into something truly meaningful for physicians, clinicians, and patients.

Instead, what is proposed for Meaningful Use inside of MIPS is even more complicated than what was proposed for Stage 3, and with even higher thresholds. This legacy—if not significantly changed in the MACRA/MIPS final rule, will not be one of using the enabling infrastructure of health IT to improve quality and value—but rather using it to satisfy regulatory compliance. What doctors, clinicians, and clinical informatics leaders should be doing now—analyzing and improving workflows and targeted use of health IT for specific quality and value purposes—will not happen. Instead, just as has occurred with each stage of Meaningful Use, they will be taking significant time to understand the rules and the FAQs that are certain to follow and continuing to develop workarounds and configuration “gimmicks,” particularly where the metric is not consistent with workflow.

In summary, the ACP believes that there is a place for Meaningful Use within MIPS, but it is one that plays a supportive role to improving care quality and value, and not one that promotes care information over patient care. Please see our specific recommendations and comments below, as well as an alternate proposal for Meaningful Use within MIPS, which we believe is responsive to the legislative requirements of MACRA.

1. We urge CMS to simplify the reporting requirements and scoring methodology within the proposed ACI Category and not require the volume and complexity specified in the base and performance scores.

In the new ACI system offered in the proposed rule, each practice will be challenged to track and manage so many activities of so many people and systems if it is to successfully complete the ACI component. The likelihood of a costly error will be high. Further, the amount of effort that will be required to perform, manage, and report all the measures that make up ACI is more than would have been required under the Meaningful Use Stage 2 modification rule for 2017. The number of required activities greatly exceeds the numbers for the other components of MIPS.

2. For the 2017 performance period, ACP recommends that the ACI measurement period be 90 days instead of the full calendar year as done previously with the EHR Incentive Program performance period.

It is extremely unlikely that all ECs will be prepared to report measures in the new system on January 1, 2017. Therefore, many ECs will be required to report on CMS's alternate ACI proposal of modified objectives for the 2017 performance period. CMS should acknowledge this in the final rule. Assuming a best case scenario, most practices will spend the 2017 MIPS performance period converting from a 2014 Certified Electronic Health Record Technology (CEHRT) system to a 2015 CEHRT system that will negatively impact their ability to perform all ACI measures for the full calendar year.

3. The College urges CMS to modify the base score component of ACI and remove the threshold requirements of 1 or "yes" for all proposed base measures except for the protecting patient health information attestation which ACP believes is integral to the use of Health IT.

This modification will support CMS's public statements and those of its Acting Administrator, Mr. Slavitt, outlining goals that give ECs the ability to select measures that are relevant and that move them forward in using health IT to improve value of care. ECs are going to need health IT capabilities that they do not yet have, and the ACI program should be used as a vehicle to help them make the needed transitions.

The proposed base measures, which are the same measures that physicians have already found to be cumbersome and inappropriate, do little to help ECs move forward.

Change the Start of the Initial Performance Period Under the QPP to July 1, 2017

The College urges CMS to delay the initial performance period under the OPP to July 1, 2017 rather than the proposed January 1, 2017 start date. The performance period should remain as 1 year in length overall, ending on June 30, 2018. ACP believes that this later start date for the performance period better matches Congressional intent that the performance period be as close to the payment adjustment period as possible, while still allowing for the related payment adjustments to take place in 2019 as mandated by MACRA.

Given that the final rule implementing the initial performance period for MACRA will likely not be issued until October 2016 at the earliest, CMS, physician organizations, ECs, and other affected parties would have less than three months to prepare for implementation of an entirely new Medicare payment system, OPP. While it may be feasible for the physician fee schedule to be issued and implemented in a short time frame, the MACRA rule is different because it is not simply issuing revisions to a rule that has previously been implemented. Rather the MACRA rule entails digesting long, complex policies on MIPS and APMs that have never been in existence. Significant efforts will be required by CMS, physician organizations, and others to prepare educational materials and tools and provide practices opportunities to learn how they can succeed in OPP and best meet the needs of their patients. CMS should also use the time between the issuance of the final rule and the later July 1, 2017, start date to refine the feedback mechanisms that will be utilized for OPP performance and allow for appropriate user feedback and end-to-end testing.

Improve the Opportunities for PCMHs and PCMH Specialty Practices in MIPS and for PCMHs as Advanced APMs

PCMHs and PCMH Specialty Practices in MIPS

The College sincerely appreciates CMS' active implementation of this component of the law—as it is critically important to facilitate movement by all clinicians toward

care that is truly patient-centered, coordinated, and comprehensive. ACP has been a leader in supporting the medical home model, particularly in light of the plethora of currently available research linking the model to higher quality and lower costs.

ACP recognizes that there will be a significant number of clinicians in PCMH practices that will be included in the MIPS pathway, even if CMS establishes a deeming process that would allow clinicians in medical home practices participating in programs run by states, other non-Medicare payers, and employers to become qualified advanced APM participants. These MIPS PCMH practices have taken significant steps to improve care for their patients through ongoing, meaningful, practice improvement approaches and therefore should be given the opportunity for full credit within the CPIA performance category. A number of these practices will, in fact, fall within the proposed definition from the agency (as outlined above); however, ACP believes that a number of clinicians in truly innovative PCMH practices could be left out of this opportunity and will therefore have the burden of documenting additional CPIA.

ACP recommends that CMS broaden its definition of the PCMH for the purposes of full CPIA credit to specifically be inclusive of programs that have a demonstrated track record of support by non Medicare payers, state Medicaid programs, employers, and/or others in a region or state (but that do not yet meet all of the requirements to be deemed an advanced APM):

- The programs to be included should be clearly articulated by CMS in advance, along with transparent criteria and methodology for the addition of new PCMH programs. With regard to “comparable specialty practice,” ACP also recommends that CMS broaden its definition to not only include those practices recognized by National Committee for Quality Assurance (NCQA), but also those practices that may be certified in some manner by other nationally recognized accreditation bodies or programs implemented by non-Medicare payers, state Medicaid programs, employers, and others in a region that may become available.
- Additionally, the College recommends that specialty practices should be able to attest directly to CMS and document that they meet standards comparable to those for primary care medical homes as recognized through an accreditation body, other certification process, or direct application to CMS or one of its carriers.

PCMHs as Advanced APMs—There Should Be Multiple Pathways Available

The College commends CMS for its recognition within the proposed rule regarding the unique status of the medical home within the advanced APM portfolio. *However, we are greatly concerned that CMS did not meet Congress’s intent that medical homes be able to qualify as [advanced] APMs without being required to bear more than nominal risk (even via the less stringent Medical Home Model Standard for financial risk and nominal amount).* The following explains our interpretation of the Congressional intent of the law and proposes specific steps that should be taken to modify the proposed rule to meet this intent.

A reasonable reading and interpretation of the statute provides what we believe to be the clear congressional intent—that CMS should allow a medical home to qualify as an [advanced] APM, without bearing more than nominal financial risk; if it is a medical home that meets criteria comparable to medical homes expanded under section 1115A(c). While this language is included in the discussion of the all-payer option that begins in 2021 (which is when other payer payments can be counted toward the threshold to determine if one is a qualifying APM participant), it makes clear that the intent of the law is to incentivize medical homes that are aligned with Medicare initiatives—and therefore ACP sees no reason to unnecessarily limit the initial opportunities for practices to become advanced APMs that are clearly meeting comparable criteria.

Criteria “comparable to medical homes expanded under section 1115A(c)” means:

- (1) the Secretary determines that such expansion is expected to—
 - (A) reduce spending under applicable title without reducing the quality of care; or
 - (B) improve the quality of patient care without increasing spending;
- (2) The Chief Actuary of the Centers for Medicare and Medicaid Services certifies that such expansion would reduce (or would not result in any increase in) net program spending under applicable titles; and

(3) The Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals. In determining which models or demonstration projects to expand under the preceding sentence, the Secretary shall focus on models and demonstration projects that improve the quality of patient care and reduce spending.

In sum, the Congressional intent and even the statutory language and criteria clearly do not require medical homes to bear more than nominal financial risk in order to qualify for payments as [advanced] APMs.

Nor does it require that the Secretary and the Chief Actuary determine/certify that medical homes would reduce net program spending—**rather, the applicable standard is that the Secretary determines they would “reduce spending . . . without reducing the quality of care” or “improve the quality of patient care without increasing spending” and the Chief Actuary certifies they “would reduce (or would not result in any increase in) net program spending.”** The College believes that there is abundant evidence that medical homes, at the very least, can improve the quality of care without increasing spending (although there is growing evidence from the many PCMH programs around the country that can also bring about reductions in costs).

Therefore, ACP recommends that CMS take the following steps to provide multiple pathways for medical homes to be included in the advanced APM pathway, in addition to the Comprehensive Primary Care Plus pathway proposed by CMS:

1. **Immediately initiate plans to undertake an expedited analysis of the results of the Comprehensive Primary Care Initiative (CPCi) to determine whether the statutory requirements for expansion by the Secretary are met.**
2. **Establish a deeming program or process to enable practices enrolled in medical home programs run by states (including state Medicaid programs), other non-Medicare payers, and employers as being deemed to have met criteria “comparable to medical homes expanded under section 1115A(c).”**
3. **Allow inclusion of medical home programs as advanced APMs that meet the Medical Home Model Standard for financial risk and nominal amount as outlined in the proposed rule.**

Implement Changes That Would Make More Advanced APMs Available for Physicians in All Specialties, Especially Including Those in Internal Medicine and its Subspecialties

The College expresses significant concern regarding the limited number of opportunities currently available for non-primary care specialists/subspecialists to participate in recognized APMs and Advanced APMs.

ACP makes the following specific recommendations to address this problem:

1. **Provide priority for consideration through the Physician Focused Payment Models Technical Advisory Committee (PTAC) and for Center for Medicare and Medicaid Innovation (CMMI) testing for models involving physician specialty/subspecialty categories for which there are no current recognized APMs and Advanced APM options available.** We further recommend that CMS provide a clear pathway for models recommended by PTAC to be implemented as APMs under MACRA.
2. **Reduce the nominal risk requirement for potential advanced APMs other than the Medical Home model. The current nominal risk requirement for these models is onerous—essentially requiring a maximum risk of 4 percent of total health expenditures for the attributed population.**
3. **Create a platform to expedite the testing for APM recognition of bundled payment and similar episodes of care payment models.**
4. **The College recommends the addition of a new Track within the Medicare Shared Savings Program (MSSP) that helps bridge the transition for one-sided to two-sided risk.** The feedback we have received from our members currently involved in Track One MSSP is that despite their ability presently to stay within Track One for a second 3-year contractual term, few of the participating physician-led entities currently feel they would be able—even after that 6-year period—to assume the currently required downside risk

of Tracks 2 and 3. Therefore, as a means of addressing this issue, the College has recommended that CMS add a Track to the MSSP program that includes two-sided risk, but at a level that would not place the participating practices at unreasonable financial jeopardy.

Summary and Conclusion

We look forward to working with the Congress to ensure that the new MACRA law is implemented in a successful manner that is consistent with the intent of Congress. The recommendations we offered to CMS in our letter, as summarized above, would serve to ensure the law truly improves care for Medicare beneficiaries. With these improvements, the QPP could go a long way to achieving Congress' goal of aligning payments with high quality care without imposing more unnecessary administrative burden on physicians.

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On behalf of the American Congress of Obstetricians and Gynecologists (ACOG), representing over 57,000 physicians and partners in women's health, please accept our statement for the record for your hearing titled "Medicare Access and CHIP Reauthorization Act of 2015: Ensuring Successful Implementation of Physician Payment Reforms." We thank the Senate Finance Committee for its leadership and crucial role in repealing the flawed Medicare Sustainable Growth Rate formula, and for its work enacting the bipartisan Medicare Access and CHIP Reauthorization Act (MACRA). Your continued partnership during the next phase of this process is highly valued and will make certain that the law is implemented as you intended and that the new program meets the needs of patients and physicians.

ACOG was, and continues to be, very supportive of MACRA, truly landmark legislation that holds the promise of improving our Nation's health. We applaud your work in getting MACRA passed into law and especially appreciate that you ensured that physicians would be integrally involved in determining the specifics of implementation, rather than having to struggle under a top-down, bureaucratically designed program. This aspect of the legislation, as many others, is a tremendous improvement.

Successful implementation of MACRA should ensure that women's unique health needs are being met. It is with that goal in mind that we provide the following comments regarding the Centers for Medicare and Medicaid Services' (CMS) proposed rule establishing the Quality Payment Program.

Low-Volume Threshold

ACOG remains incredibly appreciative that Congress included a statutory requirement allowing low volume Medicare providers to be excluded from reporting in the Merit-based Incentive Payment System (MIPS).

Wisely, the law is written in a way that doesn't specify the threshold, but leaves it up to CMS to determine the threshold after consultation with the physician community. CMS has proposed a threshold of 100 patients and \$10,000 in submitted charges. Under this threshold, many ob-gyns, particularly those who deliver surgical care, would be required to invest in reporting infrastructure, but may not meet the 20-case minimum for measures to be scored, making them ineligible for positive payment adjustments.

While 92 percent of obstetrician-gynecologists (ob-gyns) participate in Medicare, many do not have a significant proportion of Medicare beneficiaries in their patient panels.¹ The low-volume threshold proposed by CMS assesses volume based on the number of patients seen and the submitted charges associated with caring for Medicare patients. However, the specific threshold proposed by CMS does not accurately reflect ob-gyn practice. Ob-gyns often provide surgical care for female Medicare beneficiaries. The cost of surgery may cause ob-gyns to exceed CMS' proposed financial cap even if they see few Medicare patients during a performance period. To ensure that ob-gyns are not required to report without the ability to be scored due to

¹American Congress of Obstetricians and Gynecologists. (2013). 2013 Socioeconomic survey of ACOG Fellows. Retrieved from: <http://www.acog.org/-/media/Departments/Practice-Management-and-Managed-Care/2013SocioeconomicSurvey.pdf>.

too few cases for measures, the financial cap should be raised from the proposed \$10,000 to \$30,000.

In addition, CMS should align the patient cap with the Comprehensive Primary Care Plus (CPC+) program's patient panel requirement of 150 Medicare Part B patients, as opposed to the proposed 100 patient threshold. While ob-gyns are currently excluded from participating in CPC+, it is inappropriate to hold any practice to two different low-volume thresholds. Two different thresholds will cause confusion and keep practices that fall in the gap between programs from making the needed investments to move to comprehensive, coordinated, value-based care. This change to a consistent 150 patient threshold will help improve the program for all physician types, including ob-gyns.

Furthermore, the definition of low-volume providers should only apply to individual clinicians. CMS should develop a new, separate definition if the agency decides that groups should also have a low-volume threshold. Low-volume ob-gyns should be able to choose whether to report individually or with a group if practice partners do not meet the low-volume threshold.

We believe proper implementation of this provision would establish a threshold of 150 patients and \$30,000 in charges. Our proposed threshold would help those practices, as well as ob-gyn surgeons who provide high-cost services, but see few Medicare beneficiaries.

We were pleased to hear during his remarks before the Senate Finance Committee that CMS Acting Administrator Slavitt is open to alternative proposals to help low-volume and small practices. We hope that you would encourage CMS to strongly consider our suggested change.

MIPS Performance Period

Consistent with many of our colleagues in the physician community, ACOG is deeply concerned with the proposed start date of January 1, 2017 for the first performance period. We feel strongly that the first performance period should begin no earlier than July 1, 2017 and be shortened to 6 months to ensure that there is a greater opportunity to educate ob-gyns on the Quality Payment Program. Delaying the start date for the first performance period will increase the odds that CMS has the appropriate systems and technical assistance in place to support ob-gyns and other providers as they begin reporting on performance.

ACOG is committed to partnering with CMS and our members to enable ob-gyns to thrive under MACRA. However, few ob-gyns will be able to succeed under the currently proposed timeline, especially since many ob-gyns are not currently participating in the core components of MIPS—the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM) program, and the Medicare Electronic Health Record (EHR) Incentive Program. In order to successfully participate in the program, ob-gyns need several months to put into place the data collection systems needed to facilitate reporting. The short timeframe between the finalization of the rule and January 1 is not enough time to ensure successful participation.

Setting the performance year too soon will also compromise the ability of vendors, registries, EHRs, and others to update their systems to meet program requirements. The MIPS program asks that these entities incorporate a significant number of new measures, including an entirely new category of clinical practice improvement activities (CPIAs). We are concerned that, given the proposed performance period start date, there will be inadequate time to not only include new measures but also to test and ensure the data submitted is accurate and reliable. The time frame proposed does not allow for these entities to validate new data entry and testing tools, which can also exacerbate usability issues and add to the existing problems with this technology. Furthermore, EHRs are expected to undergo a significant overhaul of their systems to comply with the 2015 certification requirements. To date, however, there are no 2015 certified products available and most expect that physicians will not have this updated technology by January 2017, requiring physicians to use alternatives to meet the ACI requirements and limiting those in alternative payment models (APMs) from utilizing the benefits of the new technology.

The statutory language for the MIPS and APM categories does not require the use of a full calendar reporting period. The MIPS definition simply uses the term "performance period," avoiding the word "year" to allow CMS flexibility. Indeed, CMS recognizes this authority to set a shorter reporting period for the CPIA category and proposes a minimum 90-day reporting period. The APM statutory language also in-

cludes language noting that the reporting period “may be less than a year.”² We urge the Committee to encourage CMS to take advantage of this flexibility and allow for a shorter initial performance period, in addition to a delayed start date.

Composite Performance Score Methodology

ACOG appreciates the Congressional intent of MACRA to, among other things, streamline incentive programs, reduce the administrative burden on physicians, and ensure that metrics are relevant to each physician’s patients. We believe a large part of physician acceptance and satisfaction with MACRA will be determined by how easily an individual doctor can understand and comply with the performance scoring methodology.

MACRA is an enormous improvement over previous law in many ways, including that it reduces the reporting requirement from three programs to one. We very much support this important change in the law, but it is important that we remember that many ob-gyns, especially those not in large group practices, do not currently participate in the existing programs that will make up MIPS. These ob-gyns face a steep learning curve, lacking experience in the previous programs.

Successful implementation must ensure a simplified, user-friendly system that is transparent and predictable. Instead, CMS’s implementation proposal, in particular, the proposed calculation methodology for the composite performance score, is overly complex and lacks transparency. The calculation will be difficult to replicate without an intimate knowledge of the minutia of the formula, potentially resulting in a lack of trust in the scores that ob-gyns receive from CMS.

Ob-gyns and other providers need to know how their performance will be measured and assessed prior to the performance period. Instead, we find CMS’s proposal lacking in detail of how the benchmarks will be scored. We are also troubled that the benchmark year 2015 may not have high-quality data available due to the transition from International Classification of Diseases—(ICD) 9 to ICD-10 midway through the calendar year. While 2016 data may still reflect that transition and may not be of the highest quality, its consistent use of codes makes it the preferable approach.

ACOG is encouraging CMS to exercise flexibility where Congress allowed it, including when determining scoring thresholds. The proposed rule was unclear as to whether CMS intends to use a single numerical threshold or a range of scores to determine the MIPS adjustment factors. We recommend using a range of scores as opposed to a single number that would create arbitrary cutoffs for the physicians that cluster around the mean or median performance level. In that case those above the performance threshold would still receive a positive adjustment factor and those below would receive a negative adjustment factor, as outlined in the statute, but the cluster of physicians around the mean/median would be held harmless. This represents a more accurate way to judge performance and will avoid both subjective penalties and incentives for those whose performances are very similar to one another.

Simultaneously, we suggest that CMS delay incorporating improvement into the composite scoring methodology at this time. MIPS is an entirely new reporting program with new measures, new requirements, and new categories that will take significant education for physicians and other participants to understand. CMS should take advantage of the flexibility Congress built into the statute and delay factoring improvement into scoring until at least the second year, to ensure a successful launch of the program prior to evaluating future improvement.

Finally, ACOG has requested that CMS provide individual clinician and group feedback for eligible clinicians reporting as part of a group to help providers determine whether to continue reporting with the group or change to individual reporting. ACOG recommends that CMS aim to display feedback and performance measurement information in graphic form with additional details displayed elsewhere. In addition, the reports should include high-level overall performance information and drill down tables with individual patient information. There have been ongoing problems with physicians’ ability to access their feedback reports due to the overly complicated log-in process. ACOG recommends that CMS improve the log-in process for accessing reports to ensure it is simple and user-friendly. It should also be possible for individual physicians within a group practice to access their own reports directly rather than through a group. Additionally, ACOG has requested that CMS

²Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-focused Payment Models. 81 FR 28382. (May 9, 2016). At § 1833(z).

develop a portal so that ob-gyns are able to accurately estimate how their current performance will affect their payment adjustment. This will allow for ongoing feedback throughout the performance period, not just when reports are released to providers.

Medical Home Model and Medicaid Medical Home Model

ACOG has a strong history of support for medical homes, as a way to ensure continuity and coordination of care for women from adolescence, through the reproductive years and pregnancy, menopause and beyond. Ob-gyns are trained to provide primary care services to women throughout their life course, not just during their reproductive years. Ob-gyns play a critical role in providing primary and preventive care to women in the United States, and an ob-gyn is often the only provider a woman sees on a regular basis.³

CMS proposes to allow pediatric medicine, but not obstetrics and gynecology, to participate in the Medical Home Model and Medicaid Medical Home Model demonstrations, an exclusion that makes no sense to us since most pediatric providers care for very few Medicare beneficiaries. MACRA is silent on which provider types should qualify, leaving it up to CMS and physician input. We believe the decision of which doctors should be included should be based on qualifications, not specialty designation. But certainly if specialties are going to be designated, obstetrics and gynecology must be on the approved list. As the population ages, there will be a greater need for ob-gyns to care for older women, including in a primary care capacity. Many ob-gyn generalists are able to meet the other criteria laid out in the Medical Home Model definition. It is important that CMS also include ob-gyns in multi-payer models to ensure that ob-gyns and the women they care for are fully included in alignment efforts.

CMS's overly narrow interpretation of primary care is a detriment to women's health. To correct this, CMS should add Physician Specialty Code "16 Obstetrics and Gynecology" to the list of eligible specialty types that can participate in both Medical Home Models. Including ob-gyns would accurately reflect the training received by ob-gyns in residency and the care they provide every day. Ob-gyns do not just focus on the reproductive system. Rather, they are trained to provide primary care services to women throughout their life course. Preventive counseling and health education are essential and integral parts of the practice of ob-gyns as they advance the individual and community-based health of women of all ages.⁴ During the annual well-woman examination, ob-gyns provide screening, evaluation, counseling, and immunizations, among other services. They provide nutritional and exercise counseling; cardiovascular disease screening; diabetes screening, diagnosis, and management; risk counseling and discussion of psychosocial topics, including mental health issues and substance use disorders; and cancer screening, including colon and lung, as well as breast, cervical, endometrial, and ovarian.

In the same vein, it is important that CMS add code "16 Obstetrics and Gynecology" to the eligible list of specialties that can participate in a Medicaid Medical Home Model. As the payer for more than half of births in the country, Medicaid is integral to the delivery of women's health care.⁵ Women of reproductive age, including Medicaid beneficiaries, are a unique patient population and many of their primary care needs can effectively be met and managed by ob-gyns. Dismissing the care delivered to this significant portion of the population and foreclosing ob-gyns' opportunity to improve their practice infrastructure and invest in care coordination activities is a disservice to the millions of women enrolled in Medicaid and is a lost opportunity for aligning the health system and realizing potential cost-savings to the Medicaid program.

Advancing Care Information and 2014-edition Certified Electronic Health Record Technology (CEHRT)

ACOG has long espoused the potential of electronic health records to help ob-gyns improve the quality, safety, and efficiency of the care they provide patients. Yet the proposed CMS requirement that ob-gyns and other providers must report using the

³Udem, T., and Stewart, E. (2014). Perception is everything: How women view their OB/GYN providers. Congressional Leadership Conference. Mandarin Oriental, Washington, DC. March 2, 2014.

⁴American College of Obstetricians and Gynecologists. The scope of practice of obstetrics and gynecology. Approved by the Executive Board on February 6, 2005.

⁵Markus, A.R., Andres, E., West, K.D., Garro, N., Pellegrini, C. (2013). Medicaid covered births, 2008 through 2010, in the context of the implementation of health reform. *Women's Health Issues*. 23(5):e273–e280.

2015 edition of certified electronic health record technology (CEHRT) starting in 2018 is just not practical. Of course, using the most up-to-date technology is ideal. Today, though, no certified software meets the 2015 edition criteria, and widespread access to and adoption by all providers of the 2015 edition is not likely before 2018. Instead, CMS should allow physicians to continue to use the 2014 edition technology, or a combination of 2014 and 2015 technology, until it confirms that 2015 edition technology is readily available and cost-effective to practices. In the interim, we hope the Committee will encourage vendors to incorporate new MIPS measures into their systems to ensure physicians can report via those tools.

Thank you again for the opportunity to submit a written statement for the record. ACOG looks forward to our continued partnership with the Senate Finance Committee to ensure that MACRA is implemented as Congress intended. Please do not hesitate to contact me or ACOG's Director of Federal Affairs Rachel Tetlow at rtetlow@acog.org or 202-863-2534 should you have any questions.

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On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit comments on ensuring the successful implementation of the physician quality payment program (QPP) mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The implementation of the MACRA's QPP will have a significant impact, both on physicians and the hospitals with whom they partner. According to the AHA Annual Survey, hospitals employed more than 249,000 physicians in 2014, and had individual or group contractual arrangements with at least 289,000 more physicians—a significant portion of the 800,000 clinicians the Centers for Medicare and Medicaid Services (CMS) estimates will be impacted by the MACRA. Hospitals that employ physicians directly will help defray the cost of the implementation of and ongoing compliance with the new physician performance reporting requirements under the Merit-based Incentive Payment System (MIPS), as well as be at risk for any payment adjustments. Moreover, hospitals may participate in advanced alternative payment models (APMs) so that the physicians with whom they partner can qualify for the bonus payment and exemption from the MIPS reporting requirements.

Given its significance to the hospital field, the AHA is carefully monitoring the implementation of the QPP. CMS's recent Notice of Proposed Rulemaking includes a number of policies we support, including a reduction in the number of required quality measures in the MIPS, movement towards greater flexibility in meeting meaningful use in the advancing care information (ACI) category of the MIPS, and a flexible approach to the certified electronic health record (EHR) and quality measurement criteria in the APM track. However, we believe significant changes must be made to policies that may impinge upon the ability of hospitals and physicians to successfully participate in the QPP. Specifically, we believe the QPP should include:

- An expanded definition of advanced APMs that recognizes the substantial investments that must be made to launch and operate APM arrangements;
- A quality and resource use measure reporting option in which hospital-based physicians can use CMS hospital quality program measure performance in the MIPS;
- A socioeconomic adjustment in the calculation of performance as needed; and
- Alignment between the hospital meaningful use program and the ACI category of the MIPS, and simplified ACI requirements.

In addition, we urge Congress to consider changes to the fraud and abuse laws to allow hospitals and physicians to work together to achieve the important goals of new payment models—improving quality, outcomes and efficiency in the delivery of patient care.

Detailed information about our suggestions for improvement to the implementation of the QPP mandated by MACRA are below.

DEFINITION OF ADVANCED APMS

The MACRA provides incentives for physicians who demonstrate significant participation in APMs. **The AHA supports accelerating the development and use of alternative payment and delivery models to reward better, more efficient, coordinated and seamless care for patients.** Many hospitals, health systems and payers are adopting such initiatives with the goal of better aligning provider incentives to achieve the Triple Aim of improving the patient experience of care (including quality and satisfaction), improving the health of populations and reducing the per capita cost of health care. These initiatives include forming accountable care organizations, bundling services and payments for episodes of care, developing new incentives to engage physicians in improving quality and efficiency, and testing payment alternatives for vulnerable populations.

Despite the progress made to date, the field as a whole is still learning how to effectively transform care delivery. There have been a limited number of APMs introduced so far, and existing models have not provided participation opportunities evenly across physician specialties. Therefore, many physicians may be exploring APMs for the first time.

As a general principle, the AHA believes the APM provisions of the MACRA should be implemented in a broad manner that provides the greatest opportunity for physicians who so choose to become qualifying APM participants. Particularly in the early years of MACRA implementation, the QPP should reflect an expansive approach that encourages and rewards physicians who demonstrate movement toward APMs.

For this reason, the AHA is extremely disappointed that few of the models in which hospitals have engaged will qualify as advanced APMs as defined in CMS's proposed rule. We urge the Administration adopt a more inclusive approach. Specifically, we are concerned about CMS's proposed generally-applicable financial risk standard, under which an APM must require participating entities to accept significant downside risk to qualify as an advanced APM. We recommend the expansion of the definition of financial risk to include the investment risk borne by providers who participate in APMs, and the development of a method to capture and quantify such risk. We also urge CMS to update existing models, such as the Bundled Payments for Care Initiative and the Comprehensive Care for Joint Replacement, so that these models would qualify as advanced APMs.

We believe it is fair, as well as important, that the QPP recognize the significant resources providers invest in the development of APMs. For example, to successfully implement an APM, providers must acquire and deploy infrastructure and enhance their knowledge base in areas, such as data analytics, care management and care redesign. Further, one metric for APM success—meeting financial targets—may require providers to reduce utilization of certain high-cost services, such as emergency department visits and hospitalizations through earlier interventions and supportive services to meet patient needs. However, this reduced utilization may result in lower revenues. Providers participating in APMs accept the risk that they will invest resources to build infrastructure and potentially see reduced revenues from decreased utilization, in exchange for the potential reward of providing care that better meets the needs of their patients and communities and generates shared savings. This risk is the same even in those models that do not require the provider to repay Medicare if actual spending exceeds projected spending.

Although the clinicians participating in shared savings-only models are working hard to support the Administration's goals to transform care delivery, under CMS's proposal they will not be recognized for those efforts. We believe this would have a chilling effect on experimentation with new models of care among providers that are not yet prepared to jump into two-sided risk models.

RECOMMENDED CHANGES TO THE MIPS

The MACRA sunsets three existing physician quality performance programs—the physician quality reporting system, Medicare EHR Incentive Program for eligible professionals and the value-based payment modifier—and consolidates aspects of those programs into the MIPS. The MIPS will be the default QPP track for eligible clinicians. The MIPS must assess eligible clinicians on four performance categories—quality measures, resource use measures, clinical practice improvement activities and ACT, a modified version of the historical meaningful use program. Based on their MIPS performance, eligible clinicians will receive incentives or pen-

alties under the Medicare physician fee schedule of up to 4 percent in calendar year (CY) 2019, rising gradually to a maximum of 9 percent in CY 2022 and beyond.

The AHA urges the adoption of a MIPS that measures providers fairly, minimizes unnecessary data collection and reporting burden, focuses on high-priority quality issues, and promotes collaboration across the silos of the health care delivery system. To achieve this, we believe the QPP should encompass the following characteristics:

- Streamlines the focus of the MIPS measures to reflect national priority areas;
- Allows hospital-based physicians to use their hospital's quality reporting and pay-for-performance program measure performance in the MIPS;
- Employs risk adjustment rigorously—including sociodemographic adjustment, where appropriate—to ensure providers do not perform poorly in the MIPS simply because of the types of patients they care for; and
- Moves away from an “all-or-none” scoring approach for the ACI category, and ensure that programmatic changes for eligible clinicians are aligned with those of the EHR Incentive Program for eligible hospitals.

The AHA agrees with several CMS proposals that are aligned with these recommendations, including a reduction in the number of required quality measures. However, we urge significant changes to policies discussed below to reduce unnecessary burden, address technical problems, and maximize the ability of the MIPS to compare performance fairly.

Use of Hospital Quality Measures for Hospital-Based Clinicians

The AHA urges adoption of a CMS hospital quality program measure reporting option for hospital-based clinicians in the MIPS as soon as possible. A provision in the MACRA allows CMS to develop MIPS-participation options for hospital-based clinicians so they can use their hospital's quality and resource use measure performance for the MIPS. We believe using hospital measure performance in the MIPS would help physicians and hospitals better align quality improvement goals and processes across the care continuum, and reduce data collection burden.

While we are disappointed that the agency does not formally propose such an option for the CY 2019 MIPS, we look forward to working with all stakeholders in the coming months to make hospital-based physician reporting in the MIPS a reality.

Socioeconomic Adjustment

The AHA strongly urges the robust use of risk adjustment—including socioeconomic adjustment, where appropriate—to ensure caring for more complex patients does not cause providers to appear to perform poorly on measures. It is a known fact that patient outcomes are influenced by factors other than the quality of the care provided. In the context of quality measurement, risk adjustment is a widely accepted approach to account for some of the factors outside the control of providers when one is seeking to isolate and compare the quality of care provided by various entities. As noted in the National Quality Forum's 2014 report on risk adjustment and sociodemographic status, risk adjustment creates a “level playing field” that allows fairer comparisons of providers. Without risk adjustment, provider performance on most outcome measures reflect differences in the characteristics of patients being served, rather than true differences in the underlying quality of services provided.

The evidence continues to mount that sociodemographic factors beyond providers' control—such as the availability of primary care, physical therapy, easy access to medications and appropriate food, and other supportive services—influence performance on outcome measures. For example, in January 2016, the National Academy of Medicine (NAM) released the first in a planned series of reports that identifies “social risk factors” affecting the health outcomes of Medicare beneficiaries and methods to account for these factors in Medicare payment programs. Through a comprehensive review of available literature, the NAM's expert panel found evidence that a wide variety of social risk factors may influence performance on certain health care outcome measures, such as readmissions, costs and patient experience of care. These community issues are reflected in readily available proxy data on socioeconomic status, such as U.S. Census-derived data on income and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. The agency also recently proposed to adjust several measures in the Medicare Advantage Star Rating program for sociodemographic factors. Yet, to date,

CMS has resisted calls to incorporate sociodemographic adjustment into the quality measurement programs for physicians, hospitals, and other providers.

Unfortunately, failing to adjust measures for sociodemographic factors when necessary and appropriate can harm patients and worsen health care disparities by diverting resources away from physicians, hospitals and other providers treating large proportions of disadvantaged patients. It also can mislead patients, payers and policymakers by blinding them to important community factors that contribute to poor outcomes. Physicians, hospitals and other providers clearly have an important role in improving patient outcomes and are working hard to identify and implement effective improvement strategies. However, there are other factors that contribute to poor outcomes. If quality measures are implemented without identifying sociodemographic factors and helping all interested stakeholders understand their role in poor outcomes, then the nation's ability to improve care and eliminate disparities will be diminished.

MIPS Advancing Care Information Category

CMS proposes a new framework for the Medicare EHR Incentive Program for MIPS-eligible clinicians. **The AHA supports changes to the meaningful use program for physicians that begin to offer flexibility in how physicians and other eligible clinicians are expected to use certified EHRs to support clinical care. As these changes are implemented, it will be essential to ensure that program requirements are aligned across all participants, including physicians, hospitals, and critical access hospitals.** This alignment is essential to ensuring the ability of providers to share information and improve care coordination across the continuum.

CMS proposes two pathways for provider participation in the ACI performance category with base requirements and an additional performance score. **The AHA appreciates the movement toward flexibility in the measures, but we remain concerned that the reporting burden will remain high. The AHA recommends that CMS simplify the ACI requirements by permitting eligible clinicians to use objectives and measures derived from the EHR Incentive Program Modified Stage 2. We also recommend a delay in the introduction of Stage 3 until a date no sooner than CY 2019.**

In addition, the AHA supports the elimination of an all-or-nothing approach that makes clear that attainment of 70 percent of the objectives and measures in meaningful use afford full credit in this performance category. Prior experience has demonstrated that the complexity of the measures, the length of the reporting period and immature standards and technology present challenges to successfully meeting program requirements.

The AHA strongly supports the goals of information sharing to improve care, engage patients, and support new models of care. The proposed rule would require all hospitals, CAHs and physicians that participate in the meaningful use program to attest that they did not “knowingly and willfully take action to limit or restrict the compatibility or interoperability” of their certified EHR. Additionally, the proposed rule would require two additional attestations:

- (1) How the technology is implemented to conform with standards, allow patient access and support secure and trusted bi-directional exchange; and
- (2) That hospitals, CAHs or physicians responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, health care providers, and other persons, regardless of the requester's affiliation or technology vendor.

The AHA is concerned that proposals that physicians attest to not participating in information blocking—and cooperate with EHR surveillance activities—do not focus on the core issues at hand. **The AHA recommends that the Administration, including CMS and the Office of the National Coordinator for Health IT, consider the extent to which we have the standards, technology and infrastructure in place to facilitate information exchange with a focus on mechanisms to ensure the availability of efficient and effective trusted exchange in practice, and robust testing of products used to support exchange.** Without those building blocks in place, providers are challenged to efficiently and effectively exchange and use health information.

The AHA also recommends adoption of only one of the three proposed attestations about information blocking—that hospitals and CAHs participating in the meaningful use program and clinicians participating in the

Medicare quality program attest that they have not “knowingly and willfully taken action (such as to disable functionality) to limit or restrict the compatibility or interoperability of their certified EHR.”

LEGAL IMPEDIMENTS TO IMPLEMENTATION OF NEW PAYMENT MODELS

By tying a portion of most physicians’ Medicare payments to performance on specified metrics and encouraging physician participation in APMs, the MACRA takes another step in the health care field’s movement to a value-based paradigm from a volume-based approach. To achieve the efficiencies and care improvement goals of the new payment models, hospitals, physicians and other health care providers must break out of the silos of the past and work as teams. Of increasing importance is the ability to align performance objectives and financial incentives among providers across the care continuum.

Outdated fraud and abuse laws, however, are standing in the way of achieving the goals of the new payment systems, specifically, the physician self-referral (Stark) law and Anti-Kickback statute. These statutes and their complex regulatory framework are designed to keep hospitals and physicians apart—the antithesis of the new value-based delivery system models. A recent AHA report, *Legal (Fraud and Abuse) Barriers to Care Transformation and How to Address Them*, examines the types of collaborative arrangements between hospital and physicians that are being impeded by these laws and recommends specific legislative changes.

Congress should create a clear and comprehensive safe harbor under the Anti-Kickback Law for arrangements designed to foster collaboration in the delivery of health care and incentivize and reward efficiencies and improvement in care. Arrangements protected under the safe harbor would be protected from financial penalties under the Anti-Kickback civil monetary penalty law. In addition, the Stark Law should be reformed to focus exclusively on ownership arrangements. Compensation arrangements should be subject to oversight solely under the Anti-Kickback Law.

CONCLUSION

Thank you for the opportunity to share our views on the implementation of the MACRA. The AHA looks forward to working with Congress, CMS and all other stakeholders to ensure successful implementation of physician payment reforms enhances the ability of hospitals and physicians to deliver quality care to patients and communities.

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July 13, 2016

U.S. Senate
Committee on Finance
Dirksen Senate Office Building
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Chairman Hatch, Ranking Member Wyden, and the honorable members of the Senate Committee on Finance (Committee), on behalf of the American Society of Plastic Surgeons (ASPS), we submit this testimony regarding the July 13, 2016 Committee hearing reviewing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) implementation process. ASPS is grateful for your continued attention to the MACRA rulemaking process.

ASPS is the largest association of plastic surgeons in the world, representing more than 7,000 members and 94 percent of all American Board of Plastic Surgery board-certified plastic surgeons in the United States. Plastic surgeons provide highly skilled surgical services that improve both the functional capacity and quality of life of patients. These services include the treatment of congenital deformities, burn injuries, traumatic injuries, hand conditions, and cancer. ASPS promotes the highest

quality patient care, professional and ethical standards, and supports education, research and the public service activities of plastic surgeons.

As mentioned above, plastic surgeons perform a wide array of procedures and surgeries. This diversity makes defining quality care a difficult task. As surgical specialists, plastic surgeons have unique issues with the MACRA implementation process, and today we address the Committee regarding three specific areas where the Centers for Medicare and Medicaid Services (CMS) has deviated from Congressional intent:

1. SECTION 101(e) of the law creates a new Physician-Focused Payment Technical Advisory Committee (PTAC) to provide recommendations to the Secretary of Health and Human Services on the development of new physician-focused alternative payment models. Late in 2015, CMS staff stated in public forums that it is “under no statutory obligation” to follow the recommendations of the PTAC. This clearly disregards Congress’s desire to ensure that the design of these models is heavily influenced by the practitioners that form their foundation. Additionally, ASPS is concerned that the review criteria employed by the PTAC will not result in sufficient engagement with specialty medicine providers in the evaluation of proposed new specialty-focused payment models.
2. SECTION 102 of the law directs the Secretary to provide \$15 million annually to support the development of physician quality measures, beginning in FY15. FY15 came and went without these funds being released, FY16 is nearing its end, and CMS has given no indication of when they will be made available. Furthermore, ASPS has heard troubling indications that CMS may determine that medical specialty societies will not be eligible to apply for this funding. Because they play a significant role in the development of evidenced based clinical guidelines and provide a great deal of time and resources measuring specialty-specific quality, medical specialty societies are uniquely positioned to develop quality measures for physician specialists. If CMS enacts this provision as suspected, it will disadvantage specialist physicians and undermine efforts to develop useful measures.
3. SECTION 105(b) of the law directs CMS to share Medicare claims data with Qualified Clinical Data Registries (QCDR) to support quality improvement and patient safety. Earlier this year, CMS stated that it intended not to implement this provision. This month, CMS released a Final Rule partially implementing this section in a manner that does not respect the law as written, and will not permit QCDR’s to access real-time Medicare claims data.

Thank you very much for this opportunity to address the Committee and for your consideration of our comments. CMS should not be allowed to repeat the mistakes of the past, and we implore Congress to ensure that its statutory will is respected in the design of MACRA. Additionally, ASPS is happy to work with you and CMS to ensure CMS implements the law appropriately. Please do not hesitate to contact Patrick Hermes, ASPS Senior Manager of Advocacy and Government Affairs, if you have any comments, questions, or concerns. He can be reached at phermes@plasticsurgery.org or (847) 228-3331.

THE DOCS4PATIENTCARE FOUNDATION

The Medicare Access and CHIPS Reauthorization Act of 2015 (MACRA) is the largest body of legislation affecting health care since the passage of Obamacare in 2009. It is also the most expensive since Obamacare, costing billions of dollars per year to implement and maintain. The Docs4PatientCare Foundation is pleased to submit the following comments regarding MACRA to the Senate Committee on Finance.

Introduction and Overview

To fully understand the nature of the MACRA rule and our comments regarding the same, it is necessary to review the historical context in which MACRA was passed. MACRA consolidates several existing programs including the Meaningful Use health information technology program, the Value-Based Purchasing Program and the PQRS quality reporting program. In the past these programs existed in separate bodies of legislation/regulation and thus were never considered together in their entirety until now. This brings many previously discussed yet still unresolved issues regarding health care delivery to the surface for conversation and review.

This legislation brings back into the spotlight many issues regarding the four major components of the proposed rule. The first issue is the role of third party quality

measurement in the practice of medicine. The “quality movement” in medicine has been in existence for at least 10 years since the first version of the Physician Quality Reporting System (PQRS) was issued in 2006. Since then the “quality movement” has enjoyed increasing momentum based on little more than its own propaganda. The biggest single body of information regarding the alleged lack of quality in U.S. health care is based on a study issued by the World Health Organization in 2000, the *World Health Report 2000*. This has led to other misguided reports from similarly inclined institutions that compare infant mortality rates and life expectancies across a large number of countries including the United States. When compared against per capita health-care spending it becomes clear that, although the United States spends the most per capita on health care (currently about \$8,750 per individual), the ranking of the United States regarding life expectancy and infant mortality are generally in the mid-30s and are even lower among industrialized nations. These data are routinely used to construct an intellectual “shell game” based on the assumption that infant mortality and life expectancy are valid measures of a health-care system’s performance. The misguided conclusion is that the United States is not getting its money’s worth from its health-care system.

A significant body of information demonstrates that these assumptions regarding the relationship of infant mortality and life expectancy to overall health-care system performance are untrue. Japan, for example, is usually touted as the nation with the highest life expectancy while spending less than half the amount per capita for health care as does the United States. If life expectancy were truly a measure of health-care system performance then one would expect people of Japanese ancestry who live in the United States to have a lower life expectancy because they are “victims” of a poor health-care system. In fact the opposite is true: people of Japanese ancestry have the same life expectancy whether they live in the United States or Japan. A truly objective analysis of the data clearly demonstrates that there is no statistical relationship between life expectancy and per capita spending on health care. Life expectancy has instead been shown to be associated with factors independent of the health-care system—such as cleanliness of living conditions, income, literacy rate, diet, lifestyle and genetics.

Using infant mortality as a measure of overall health-care system performance suffers from different yet equally significant shortcomings. The methods of measuring infant mortality differ greatly among countries. The United Nations Statistics Division defines a live birth as an infant, once removed from its mother, which is breathing or shows other evidence of life such as a heartbeat, pulsation of the umbilical cord or movement of voluntary muscles regardless of gestational age. However, Switzerland’s definition also stipulates the infant must be at least 30 cm long at birth to be considered living. Italy has three different definitions of infant death depending on region within the nation. Japan, Finland, France and Norway all have different approaches to counting births from citizens living outside the host nation. In addition, infant mortality also is affected by parental behavior including marital status. No health-care system has any control over issues such as these.

Perhaps most telling is that the Editor-in-Chief of the original *World Health Report 2000*, Philip Musgrove, Ph.D., opined in the *New England Journal of Medicine* in 2010 that the data from the report were being used improperly for the purpose of ranking health-care systems and that “it is long past time for the zombie number(s) to disappear from circulation.”

Why do supporters of big government-based health-care reform continue to cite these numbers as evidence that America is not getting value regarding health-care spending? Here’s where the intellectual shell game occurs. The rhetoric regarding “not getting one’s money’s worth” is used to shift the health-care reform conversation from a paradigm of cost and access to one of quality and value. This serves two purposes for those who endeavor to control the narrative on health-care reform. First, the shift from a cost/access argument to one involving quality/value moves the conversation from easily measurable elements (cost and access) to elements which are impossible to measure (quality and value). Indeed quality and value do not even possess objective units of measurement. Thus, any health-care reform measures implemented in the name of quality and value cannot be proven to fail based on objective measurement. In such an intellectual vacuum a perception of success can be created by an effective narrative. There is no need whatsoever for the measures in question to actually succeed.

The second purpose is equally sinister. A conversation based on cost and access will by its nature distribute responsibility for rising health-care costs appropriately across all competitive stakeholders within the health-care system. It is intuitively

obvious that in a cost-based conversation, blame is shared among insurance plans, government regulations, hospitals/health systems, and physicians themselves. Conversely, a value/quality conversation allows the predominance of blame to be placed upon physicians and others who touch patients for a living.

Into such a “fertile” environment the proposed MACRA rule has been introduced. A conversation based on quality/value makes a 962 page rule which proposes over 450 quality measures appear reasonable. And no matter what the outcome, its supporters will claim success and support that claim with well constructed rhetoric. But once the quality/value vs cost/access shell game has been recognized, the proposed rule looks quite different. It has been estimated that the cost of reporting quality measures alone is over \$15 billion per year. Since quality reporting is one of four major components to the proposed rule one can roughly estimate the total cost of the proposed rule to be at least \$60 billion per year. Thus when the proposed rule is evaluated in the appropriate cost/access paradigm, MACRA must save \$60 billion per year before the first penny of benefit is realized. In this framework the proposed MACRA rule quickly collapses under its own weight.

Comments Regarding Specific Parts of the Rule

1. Quality reporting. “Eligible clinicians” must report on six quality measures chosen from a list of 465 options. These must include at least one “cost-cutting measure” and one “outcomes measure.” Supporters of the proposed rule point out that this is fewer than the nine quality measures that were originally required under the Meaningful Use guidelines. However, it is widely recognized that, with rare exceptions, such quality measures have never been shown to improve outcomes. Under the Meaningful Use program such quality measures have generated huge amounts of data reported to CMS that have never been read or analyzed. Continuing such a practice ensures that the \$15 billion a year that is currently spent on quality reporting will continue to be wasted.

Respected leaders within the health IT and government communities have criticized quality measures. Former CMS Administrator Donald Berwick in December 2015 proposed nine steps to enter the “moral era” of health care. These included stopping excessive measurement and abandoning complex incentives. He proposed a 50% reduction in number of the quality metrics reported. This would support a reduction from nine quality measures—beyond the proposed six—down to four. John Halamka, Chief Information Officer at Beth Israel Deaconess Medical Center and one of America’s leading health information technology experts, has recommended replacing all EMR and quality reporting requirements with 3 outcome-based measures chosen by each medical specialty. **We would therefore suggest that the number of quality measures required be reduced further from 6 to 3.**

2. Advancing care information. This is the section of the proposed rule which carries most of the requirements previously included in the Meaningful Use program. There is, however, one important addition to the proposed health IT/EHR requirements which is based on potentially deliberate misuse of supporting information and which carries very frightening implications. This section requires that the eligible clinician complete a three-part attestation that (1) one did not take action to knowingly restrict compatibility or interoperability, that (2) implemented technologies and electronic medical record systems are configured in a compliant manner, and that (3) one responded in good faith and in a timely fashion to medical information requests. This is part of the commitment of CMS to enhance interoperability and suppress “data blocking.” On pages 41 and 42 of the proposed rule, the requirement for clinicians to make such attestations is supported by evidence that “health-care providers” have engaged in data blocking. The source of this evidence is a report to Congress entitled *Report on Health Information Blocking* delivered to Congress in April 2015 by the Office of the National Coordinator of Health Information Technology. A careful review of that report reveals on pages 15–18 a discussion of anecdotal evidence of “potential information blocking.” However, in this discussion the term “providers” refers to large hospitals and health-care systems, not the individual physicians to whom the attestation requirements of the proposed rule are directed. The deception here is clear; whether such a deception was borne of “advantageous negligence” or malevolence is academic.

Individual physicians have absolutely no vested interest in “blocking data” or any other behavior which impairs the exchange of health information between any entities that are legally or morally entitled to such information. The notion that physicians need to complete attestations that they do not engage in such behavior is both punitive and useless. It also initiates a “slippery slope” of progressively ratcheted attestations over time to develop a quasi-legally binding culture of “allegiance” to

CMS. This is morally and ethically bankrupt. **The attestation requirement of the Advancing Care Information section must be removed.**

With few exceptions (mostly cardiology and surgery), none of the 465 options for reporting measures in the proposed rule are based on scientific method. **We propose that each of the 465 options must meet three criteria. First, it must be based on scientific method. Second, there must be a plan to review and act on the data that is reported to CMS through the guideline. Third, the reporting of such quality measures must be an automated function of the electronic medical record system and not impair, slow down or distract physicians participating directly in patient care.**

3. Calculation of performance scores. For each eligible clinician Medicare payments will be adjusted upward (bonus) or adjusted downward (penalty) based on a performance score. The score has four components: Advancing Care Information, quality measures, resource use, and clinical practice improvement. When fully implemented payments may be adjusted upward or downward by as much as 9% based on the performance score. Although CMS portrays this payment method as an improvement over the current “all or nothing” incentive/penalty system currently in use, further analysis reveals this proposed method to be worse than the current method. The problem lies in the requirement that the program is revenue neutral. There must be enough penalties assessed to fund the bonuses. This means there will never be a state in which all eligible clinicians achieve an acceptable level of compliance to avoid a penalty. Simply, performance scores must be “graded on the curve” to meet the revenue neutral requirements. This is unacceptable. **All physicians should have the opportunity to comply with the program at an adequate level to avoid penalty.**

Within the proposed rule the now infamous Table 64 offers chilling statistics for physicians in small practices (defined as less than 100 physicians). For practices of nine clinicians or less the odds are approximately 85% that they will receive a penalty rather than a bonus. Only for practices of 100 or more eligible clinicians do the odds of a bonus exceed the odds of a penalty. Although CMS is quick to point out that this is based on 2014 data and that smaller practices have significantly better reporting in subsequent years, the revenue-neutral nature of this portion of the program still mandates that performance thresholds be raised every year to ensure that there are enough losers to finance the winners. Small practices have no chance of competing against the far greater aggregate resources of the 100+ clinician practices. **We therefore propose that the revenue-neutral nature of this portion of the program be eliminated and that penalty-performance threshold scores be fixed for a number of years to give practices with less than 100 clinicians enough incentive to improve compliance and avoid penalties.**

4. Obligations of eligible clinicians regarding documentation of usage of certified EMR technology. After 6 years of Meaningful Use implementation it is not possible for any eligible clinician to meet all of the requirements under MACRA without having a certified EMR system. Thus the notion that every eligible clinician must go through an elaborate series of steps through the CMS website to obtain a certification number for the EMR system is no longer valid. We propose that the documentation requirements regarding use of certified EMR technology be eliminated for providers and that all activity regarding EMR certification take place only between CMS and the EMR vendors. It should suffice that the eligible clinician provides only a short statement from the EMR vendor documenting that an EMR is in use and that licensing fees are current.

5. Expansion of EMR surveillance by ONC under MACRA. Beginning on page 40 of the proposed rule CMS makes the argument that the Office of the National Coordinator has been authorized by the Office of Civil Rights to act as a “health oversight agency” under HIPAA to conduct ongoing surveillance of any and all EMR systems in use by eligible clinicians including access to patients’ protected health information in the name of quality monitoring. This has been widely and sternly criticized by physicians as a violation of our obligations under the Hippocratic Oath to patient privacy and is a violation of the Fourth Amendment of the U.S. Constitution. Furthermore, CMS offers no examples of past incidents of quality issues which would have been improved or events prevented by such surveillance. We therefore side with the opinions of a great number of concerned physicians that there is no ethical or quality driven justification for such practices. **We therefore propose that this expansion of EMR surveillance by ONC be eliminated.**

6. Alternative Payment Models (APMs). A detailed commentary regarding Alternative Payment Models is beyond the scope of this document. However, it is in-

teresting to note an article in the current issue of the *New England Journal of Medicine* (June 16, 2016) entitled “Early Performance of Accountable Care Organizations and Medicare.” The article concludes that contracts with ACOs under the Medicare Shared Savings Program showed reductions in Medicare savings that were either trivial (\$144 per beneficiary) or statistically insignificant (\$3 per beneficiary)

Conclusions

Although the Docs4PatientCare Foundation is pleased to submit these comments regarding the proposed MACRA rule, our participation in the commentary process should not be interpreted to mean that we support the existence of MACRA or the spirit of this law. MACRA was passed last year with bipartisan support; however, this bipartisan support came only because of the widespread need to eliminate the SGR model of calculating Medicare payments to physicians. Congress and organized medicine were so focused on this issue that the remainder of MACRA, including the Merit Incentive Payment System and Alternative Payment Models, was largely ignored during its passage. The notion that quality can be measured by a third-party long after a health-care transaction event is deeply flawed and has never been demonstrated to be effective in improving patient care outcomes. The idea that such flawed quality measurements should be used to financially punish physicians is extremely unethical. At the legislative level we support delaying the implementation of MACRA from 2017 to 2019 to allow further time for study and enough time for physician practices to prepare after the final MACRA rule is issued. We also support legislation that would eliminate future Medicare penalties to physicians based on reporting behavior in 2016, similar to the Patient Access and Medicare Protection Act of 2015.

It is appropriate to conclude with two insightful quotes from John Halamka:

When you remodel a house, there comes a point when additional improvements are not possible and you need to start again with a new structure.

And finally,

It's time to leave the profession if we stay on the current trajectory.

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The Honorable Orrin Hatch
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Dear Chairman Hatch and Ranking Member Wyden:

Thank you for scheduling the hearing entitled, “Medicare Access and CHIP Reauthorization Act (MACRA) of 2015: Ensuring Successful Implementation of Physician Payment Reforms” on Wednesday, July 13, 2016. IDSA greatly appreciates the Committee’s leadership in repealing the Medicare Sustainable Growth Rate (SGR) formula and in overseeing MACRA implementation. IDSA continues to provide input to the Centers for Medicare and Medicaid Services (CMS) on key implementation issues and to work with our members to prepare for payment reforms.

We are pleased to share with the Committee some of our recommendations for MACRA implementation and hope you will raise some of these issues with CMS Administrator Slavitt during the upcoming hearing. We provided detailed comments to CMS and below highlight some specific issues that we believe will be of interest to the Committee—such as the need for new infectious diseases (ID) quality measures and ways to better align new physician quality improvement programs with antibiotic stewardship and public health emergency preparedness. Given the Committee’s interest in physician reimbursement issues, we also want to highlight a related concern regarding the current undervaluation of the infectious diseases (ID) specialty, which is leading to a steep decline in the number of physicians pursuing ID specialization, at a time when our nation urgently needs ID physician expertise.

The Value of ID Physicians

ID physicians make significant contributions to patient care, biomedical research, and public health. Their leadership and services save lives, prevent costly and debilitating diseases, and drive biomedical innovation. ID physician involvement in patient care is associated with significantly lower rates of mortality and 30-day readmission rates in hospitalized patients, shorter lengths of hospital stay, fewer intensive care unit (ICU) days, and lower Medicare charges and payments. Some of the specific important contributions of ID physicians include:

- Providing life-saving care to patients with serious infections (such as HIV, sepsis, infections caused by antibiotic resistant bacteria, *Clostridium difficile*, and hepatitis C);
- Leading public health activities to prevent, control, and respond to outbreaks in healthcare settings and the community, and emerging infections such as Ebola and Zika virus infections;
- Leading antibiotic stewardship programs to optimize the use of antibiotics to achieve the best clinical outcomes while minimizing adverse events, limiting the development of antibiotic resistance and reducing costs associated with sub-optimal antibiotic use;
- Monitoring and managing highly complex patients with or at risk of serious infections (including organ and bone marrow transplant patients, chemotherapy patients, and others); and
- Conducting research leading to breakthroughs in the origin and transmission of emerging and re-emerging diseases, factors that make these virulent, and the development of urgently needed new antimicrobial drugs and other therapies, diagnostics, and vaccines.

MACRA Implementation: Opportunities and Challenges

IDSA is excited for the opportunities that MACRA implementation presents to realign physician payment to truly incentivize high quality care. We are hopeful that the new Quality Payment Program (QPP), which incorporates both the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) options, will offer significant improvements over the existing quality programs that it will replace. However, we are concerned that the APM option, which offers significant incentives, will not be accessible to physicians in small or mid-sized practices; and that the MIPS program, as currently structured, misses many opportunities to provide quality-based incentives.

The implementation of the new QPP will have a profound impact on ID physicians. CMS estimates that approximately 5,544 ID physicians will be participating in the MIPS program. Approximately 43% (2,300) of those physicians will experience a negative payment adjustment, equaling a \$12 million loss in Medicare allowed charges across the specialty. Given this projection, IDSA has offered CMS a series

of recommendations to strengthen the MIPS program geared toward providing the highest quality ID physician services.

Additional ID Quality Measures

Current Physician Quality Reporting System (PQRS) measures are not well-aligned with infectious disease practices. This is due in part to the overwhelming proportion of ID clinical services being delivered in the inpatient setting while most of the PQRS measures developed apply to face-to-face encounters in the outpatient setting. Aside from HIV, HCV, pneumonia vaccination and influenza immunization, there are no truly ID-specific measures on which ID specialists can report.

IDSA continues to propose relevant and meaningful ID measures for CMS to consider within the QPP. Earlier this year, we submitted two additional measure concepts (Appropriate Use of anti-MRSA Antibiotics and 72-hour Review of Antibiotic Therapy for Sepsis) into the CMS Measures Under Consideration (MUC) process, both related to advancing quality measurement of antimicrobial stewardship at the physician-level. We hope the Committee will encourage CMS to advance these into inclusion on the list of applicable measures under the quality component of MIPS. Antibiotic stewardship is critical to prevent the misuse and overuse of antibiotics that drive the development of antibiotic resistance—a serious and growing public health crisis that claims at least 23,000 lives in the U.S. a year according to the Centers for Disease Control and Prevention (CDC) and complicates a host of other medical services that rely upon safe and effective antibiotics, including the care of preterm infants and immunocompromised patients, solid organ and bone marrow transplants, cancer chemotherapy, and many surgeries.

IDSA is also pleased that MACRA provides CMS with additional funding for measure development. We believe the lack of relevant ID measures within the MIPS is partly due to the time and cost of measure development, and the additional funding from the MACRA offers an invaluable opportunity for CMS to assist in the development of measures where gaps exist. We urge the Committee to encourage CMS to use part of this funding towards the development of ID measures.

Clinical Practice Improvement Activities (CPIAs) Under MIPS

It is within this component of the MIPS where we believe ID physicians will have the most impact and will be able to participate in a meaningful way within the QPP. However, we offer several recommendations to help ensure that the robust array of appropriate ID activities is reflected in the available CPIAs.

IDSA is pleased that CMS is proposing the implementation of an antibiotic stewardship program (ASP) as a CPIA, and we recommend that CMS strengthen this approach by establishing leadership of an ASP as a high weight CPIA while maintaining participation in an ASP as a medium weight CPIA. The CDC has recommended that all ASP have a single leader who will be responsible for the program's outcomes and have noted that physicians—particularly those with formal training in infectious diseases—have been highly effective in this role. Further, the Joint Commission's Prepublication Standards for Antimicrobial Stewardship specifically cites the involvement of an infectious diseases physician in ASPs. CMS has issued two proposed rules to require ASPs in acute care hospitals and long term care facilities, aligned with the goals and objectives of the National Action Plan for Combating Antibiotic Resistant Bacteria (CARB). The growing need for stewardship activities and expert leaders to ensure their success underscores the importance of making leadership of ASP a high weight CPIA.

IDSA is also pleased that CMS has included some emergency preparedness and response activities in the CPIA list. However, we strongly believe preparedness should go beyond volunteering for domestic and international humanitarian work and emergency response and disaster assistance. It is critical that our hospitals and health systems prepare and build the capacity to respond to public health emergencies, including outbreaks such as Ebola Virus Disease, Zika, MERS-CoV, pandemic influenza and others. ID physicians are heavily involved in these intensive efforts, which often involve coordination across multiple departments in a hospital or health system and with public health entities, needs assessments, development of protocols, communications plans and other activities. IDSA recommends that CMS add additional CPIAs to encompass leadership and participation in a wide array of health care facility preparedness and response activities.

CMS has appropriately recognized the need to develop and include additional CPIAs, allowing for greater participation in MIPS. IDSA has recommended that CMS consider the following CPIA concepts: development, implementation, and oversight of infection prevention and control programs; development, implementation

and oversight of infectious diseases protocols for solid organ and stem cell transplant procedures; implementation and ongoing leadership of a hospital avoidance and timely discharge program enabled through outpatient parenteral antibiotic therapy; leadership of activities related to hospital or health system engagement with local, state or federal public health entities (such as surveillance, immunization programs, or outbreak response).

Undervaluing ID: Jeopardizing the Next Generation of ID Physicians

It is important for policymakers to understand that MACRA implementation is occurring against a complex backdrop for physicians and our healthcare system in which compensation issues are driving young physicians away from the field of infectious diseases. Data from the National Residency Match Program (NRMP) indicate a disturbing decline in the number of individuals applying for ID fellowship training, with 342 applicants in the 2010–2011 academic year and only 221 in 2016–2017. For 2016–2017, only 65% (or 218 out of 335) of available ID fellowship positions filled. In many specialty areas, all, or nearly all, available fellowship positions are typically filled. These data indicate a broader problem—the undervaluation of ID.

In 2014, IDSA surveyed nearly 600 Internal Medicine residents about their career choices. Very few residents self-identified as planning to go into ID. A far higher number reported that they were interested in ID but chose another field instead. Among that group, salary was the most often cited reason for not choosing ID. Average salaries for ID physicians are significantly lower than those for most other specialties and only slightly higher than the average salary of general Internal Medicine physicians, even though ID training and certification requires an additional 2–3 years. Young physicians' significant debt burden (\$200,000 average for the class of 2014) is understandably driving many individuals toward more lucrative specialties.

Over 90% of the care provided by ID physicians is accounted for by evaluation and management (E&M) services. These face-to-face, cognitive encounters are undervalued by the current payment systems compared to procedural practices (*e.g.*, surgery, cardiology, and gastroenterology). This accounts for the significant compensation disparity between ID physicians and specialists who provide more procedure-based care, as well as primary care physicians who provide similar E&M services but who have received payment increases simply because of their specialty enrollment designations as “primary care physicians.” Cognitive E&M services comprise a higher percentage of services provided by ID specialists than those provided by primary practice specialists such as Internal Medicine, Family Medicine or Pediatrics, based on CMS data.

Current E&M codes fail to reflect the increasing complexity of E&M work, which covers the vast majority of ID as discussed above. Without updated, accurate E&M codes, the payment reform activities included in MACRA will have only a limited impact on improving ID patient care and will fail to address the underlying problem of undervaluing ID that is driving fewer young physicians to enter the specialty. ID physicians often care for more chronic illnesses, including HIV, hepatitis C, and recurrent infections. Such care involves preventing complications and exploring complicated diagnostic and therapeutic pathways. ID physicians also conduct significant post-visit work, such as care coordination, patient counseling and other necessary follow up.

IDSA urges the Committee to direct CMS to undertake the research needed to better identify and quantify the inputs that accurately capture the elements of complex medical decision making. Such studies should take into account the evolving health care delivery models with growing reliance on team-based care, and should consider patient risk-adjustment as a component to determining complexity. Research activities should include the direct involvement of physicians who primarily provide cognitive care. Specifically, this research should:

- (1) Describe in detail the full range of intensity for E&M services, placing a premium on the assessment of data and resulting medical decision making;
- (2) Define discrete levels of service intensity based on observational and electronically stored data combined with expert opinion;
- (3) Develop documentation expectations for each service level;
- (4) Provide efficient and meaningful guidance for documentation and auditing; and
- (5) Ensure accurate relative valuation as part of the Physician Fee Schedule.

Once again, we thank the Committee for its attention to physician payment and health care quality, and we look forward to continuing to work with you in order to meet the evolving needs of our patients.

Sincerely,

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President, IDSA

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The Medical Group Management Association (MGMA) applauds the U.S. Senate Committee on Finance (Committee) for continuing to show leadership on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and is committed to working with the Committee, Congress, and the Administration to ensure a successful implementation of MACRA.

MGMA helps create successful medical practices that deliver the highest-quality patient care. As the leading association for medical practice administrators and executives since 1926, MGMA helps improve members' practices and produces some of the most credible and robust medical practice economic data and data solutions in the industry. Through its national membership and 50 state affiliates, MGMA represents more than 33,000 medical practice administrators and executives in practices of all sizes, types, structures and specialties in which more than 280,000 physicians practice.

MGMA strongly supported MACRA, which was a significant legislative and policy achievement that replaced the failed sustainable growth rate formula with stable Medicare physician payment updates and incentives to innovate and participate in new care delivery models that have the potential to reduced Medicare waste while improving patient outcomes. However, we are concerned that CMS' notice of proposed rulemaking (NPRM) implementing the new Merit-Based Incentive Payment System (MIPS) and alternative payment models (APMs) strays from the key terms and themes of MACRA to simplify quality reporting and reward the move from fee-for-service to value-based payment and delivery models. Instead, the NPRM would create a complex web of administratively burdensome reporting requirements in MIPS while limiting opportunities for practices to utilize the transitional APM payments to support their care delivery redesign.

MGMA is pleased to have the opportunity to offer this statement for the record at this critical juncture in MACRA implementation and to share with the Committee our concerns and recommendations for improving the proposed framework for MIPS and APMs. In our comment letter to CMS in response to the NPRM, we made recommendations to assist CMS and the Administration in implementing MACRA in a manner that supports physician group practices as they transform their payment and delivery approaches from fee-for-service toward value-based models. Our key recommendations include:

Beginning the first MIPS and APM performance period no sooner than January 1, 2018. Beginning January 1, 2018 would bring the measurement period closer to the payment year and provide practices with more opportunities to participate in eligible APMs by giving more time to CMS's Centers for Innovation to develop Medicare payment models and the Physician-Focused Payment Models Technical Advisory Committee to shepherd private sector models into the eligible APM track.

Shortening the quality and advancing care information (ACI) performance periods to any 90 consecutive days using sampling and attestation methodologies that ensure statistical validity. Accommodating claims-based reporting with a longer submission period, such as 6 months. Ninety days would align quality and ACI with the proposed 90-day CPIA performance period.

Finalizing the MIPS group practice assessment option, which recognizes the fundamental advantage the group practice model offers by coordinating a wide range of physician and related ancillary services in a manner that is seamless to patients.

Reducing the reporting requirements across MIPS. As proposed, physician group practices' finite resources would be spread across at least 20 measures and objectives, including a minimum of eight measures in the quality category, two measures in resource use, nine measures in ACI, and at least one measure in the CPIA category. CMS should structure MIPS to allow practices to prioritize effective and impactful improvements to patient care, rather than comply with sprawling reporting mandates.

Awarding credit across MIPS performance categories. Whenever possible, CMS should award credit in multiple categories to streamline the program and reduce redundancies.

Overhauling the eligible APM criteria and expanding the list of qualifying APMs to include legitimate CMS Innovation Center models such as Medicare Shared Savings Program (MSSP) Track 1 ACOs and the Bundled Payment for Care Improvement (BPCI) models.

Seeking opportunities to adopt private sector payment models and patient-centered medical home (PCMH) models as eligible APMs.

Conclusion

We appreciate the opportunity to submit this statement for the record to the Committee. MGMA remains committed to helping group practices and CMS understand the best way to implement MACRA in order to streamline and harmonize quality reporting programs into MIPS and develop meaningful APMs. We look forward to continuing to work with the Committee, Congress and the Administration to ensure that the rollout of these new programs is successful. We would be happy to provide you with a full copy of our comments to CMS's MIPS and APMs NPRM as well as any additional resources (www.mgma.org/MACRA).

