

MACRA AND MIPS: AN UPDATE ON THE MERIT- BASED INCENTIVE PAYMENT SYSTEM

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS SECOND SESSION

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MACRA AND MIPS: AN UPDATE ON THE MERIT-BASED INCENTIVE PAYMENT SYSTEM

THURSDAY, JULY 26, 2018

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2123 Rayburn House Office Building, Hon. Michael Burgess (chairman of the subcommittee) presiding.

Members present: Representatives Burgess, Guthrie, Shimkus, Latta, Lance, Griffith, Bilirakis, Long, Bucshon, Brooks, Hudson, Collins, Carter, Green, Engel, Matsui, Castor, Schrader, Kennedy, Eshoo, and Pallone (ex officio).

Staff present: Mike Bloomquist, Staff Director; Samantha Bopp, Staff Assistant; Adam Buckalew, Professional Staff Member, Health; Daniel Butler, Legislative Clerk, Health; Jordan Davis, Senior Advisor; Adam Fromm, Director of Outreach and Coalitions; Caleb Graff, Professional Staff Member, Health; Jay Gulshen, Legislative Associate, Health; Ed Kim, Policy Coordinator, Health; Ryan Long, Deputy Staff Director; Drew McDowell, Executive Assistant; James Paluskiewicz, Professional Staff, Health; Brannon Rains, Staff Assistant; Jennifer Sherman, Press Secretary; Josh Trent, Chief Health Counsel, Health; Hamlin Wade, Special Advisor, External Affairs; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Una Lee, Minority Senior Health Counsel; and Samantha Satchell, Minority Policy Analyst.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS [presiding]. The Subcommittee on Health will now come to order. And I recognize myself for 5 minutes for an opening statement.

Today's hearing is one that has been in the works for quite some time. As many of you know, this hearing has been rescheduled twice. But, given that we have now enacted important technical changes, providers having information on their first performance year, and this year's Quality Payment Program rules to discuss, this hearing is timely now. I am glad we can complete our due diligence, as members of the Health Subcommittee, and conduct oversight and the implementation of the Medicare Access and CHIP Reauthorization Act of 2015.

This bill, which came through the 114th Congress, is a product of careful, intricate bipartisan negotiations and was passed by both chambers of Congress with broad support. Signed into law on April 16, 2015, this bill repealed the sustainable growth rate formula for all time. The sustainable growth rate formula was for calculating annual updates to physician payment rates under Medicare. We now know that the formula, which was enacted as part of the Balanced Budget Act of 1997, turned out to be unwise.

As an OB/GYN prior to coming to Congress, I was frustrated with the annual exercise of the sustainable growth rate formula, as were many other physicians, as were Members of Congress. I would like to take a moment to remind members of what the world of physician payments looked like before the repeal or before the passage of the Medicare Access and CHIP Reauthorization Act.

Congress consistently passed legislation to override the SGR. That resulted in hundreds of billions of dollars spent that could have gone to bolstering Medicare and other health programs. Medicare providers and their patients by extension were under the constant threat of payment cuts under the sustainable growth rate formula. The formula's unrealistic assumptions of spending and efficiency have plagued the healthcare profession and our Medicare beneficiaries for a long time. The Medicare Access and CHIP Reauthorization Act repealed the SGR, provided for statutory updates to allow improved beneficiary access, and got medicine to concentrate on moving to broad adoption of a quality reporting system.

One of the most important provisions in the law was a shift from a fee schedule system toward a merit-based incentive payment system. The law left behind a pass/fail quality reporting regime whose measures were too often set up against a "one-size-fits-all" generic standard of care with no financial upside for providers. Since the merit-based system was set to go into full effect on January 1st, 2019, the first payment consequence year, from reporting provided in 2017, it is critical that we hold this hearing and hear from our witnesses, in a sense, what is working, how the transition is progressing, and where improvements have been made while seeking ways to simultaneously encourage stronger participation and reward providers already invested in the MIPS track.

The Medicare Access and CHIP Reauthorization Act required the Secretary of Health and Human Services to establish a methodology to assess merit-eligible practitioners and give each one a performance score which determines payments based on a scale of 1 to 100. In the first year, the performance benchmark was set at 3. This year it was set at 15, and the Centers for Medicare and Medicaid Services recently proposed raising it to 30 for 2019. The merit-based incentive payment system incorporated specific performance categories, including quality, resource use, clinical practice improvement activities, and meaningful use of electronic health records. The eligible population was also set to change over time. And the Centers for Medicare and Medicaid Services recently proposed to add a slate of additional providers to the program.

Overall, stakeholders and physicians have been supportive of the transition. In our third hearing, we heard from providers getting the benefits of savings by participating in the advanced alternative payment model. That said, the Medicare Access and CHIP Reau-

thorization Act was a long-term project and a viable fee-for-service model in the form of the merit-based incentive payment system needed to exist. In continuing to follow the Medicare Access and CHIP Reauthorization Act implementation, certain decisions were made by the Centers for Medicare and Medicaid Services that were for the benefit of a smooth transition, but had consequences, consequences that affected the agency's trajectory of setting the performance threshold. Given this and other developments, I believed that the law would benefit from technical updates to improve the implementation based on real-time factors. The Bipartisan Budget Act of 2018 included three technical fixes. This was done by myself, Ranking Member Green, and Representatives Roskam and Levin from the Ways and Means Committee.

The Medicare Access and CHIP Reauthorization Act changed the world of Medicare provider payments. It has laid the groundwork for increased access to quality care for beneficiaries by eliminating the uncertainty of the past, reducing physician burden, and providing incentives where previously there were none. It was never a law that was going to be fully implemented with the flip of a switch or a signing ceremony. It was designed as a long-term effort to move the Medicare program down the value continuum.

So, once again, I want to thank our witnesses for joining us today. I look forward to hearing from each of you about how the implementation of this important law is progressing.

I yield back the balance of my time and recognize the ranking member of the subcommittee, Mr. Green, 5 minutes for an opening statement.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Today's hearing is one that has been in the works for quite some time. As many of you know, this hearing has been rescheduled twice, but given that we now have enacted important technical changes; providers having information on their first performance year; and this year's Quality Payment Program Proposed Rule to discuss, I think the hearing will be better for it. So, I am glad we can now complete our due diligence as members of the Health Subcommittee and conduct oversight of the implementation of the Medicare Access and CHIP Reauthorization Act of 2015, also known as MACRA.

MACRA, which I championed through the 114th Congress, is the product of careful, intricate, bipartisan negotiations and passed both chambers of Congress with broad support. It was signed into law on April 16, 2015. Most notably, this bill repealed the sustainable growth rate (SGR) formula for calculating annual updates to physician payment rates under Medicare. We now know the SGR formula which was enacted as part of the Balanced Budget Act of 1997 was a misguided attempt to restrain federal spending in Medicare Part B.

As an OB/GYN prior to coming to Congress, I was overwhelmingly frustrated with the annual exercise of the SGR, as were many other physicians and members of Congress. I would like to take a moment to remind members what the world of physician payments looked like before MACRA.

Congress consistently passed legislation to override the SGR, which resulted in hundreds of billions in spent funds that could have gone to bolstering Medicare and other vital health care programs. Medicare providers, and their patients by extension, were under constant threat of payment cuts under the SGR. The formula's unrealistic assumptions of spending and efficiency have plagued the healthcare profession and our Medicare beneficiaries for 13 years. MACRA finally repealed the SGR, provided for statutory updates to allow improved beneficiary access, and got medicine to concentrate on moving to broad adoption of the unified MACRA quality reporting system.

One of the most important provisions in the law was the shift from a fee schedule system towards the merit-based incentive payment system, or MIPS. The law left behind a pass/fail quality reporting regime whose measures were too often set against a “one size fits all” generic standard of care with no financial upside for providers. Since MIPS is set to go into full effect on January 1, 2019—the first payment consequence year from reporting provided in 2017—it is critical that we hold this hearing and assess what is working, how the transition is progressing, and where improvements have been made, while seeking ways to simultaneously encourage stronger participation and reward providers already invested in the MIPS track.

MACRA required the Secretary of Health and Human Services to establish a methodology to assess MIPS-eligible practitioners and give each one a performance score which determines their payments based on a scale of 1 to 100. In the first year, the performance benchmark was set at 3. This year, it was set at 15 and the Centers for Medicare and Medicaid Services recently proposed raising it to 30 for 2019. MIPS incorporated specific performance categories, including, quality, resource use, clinical practice improvement activities, and meaningful use of electronic health records. The eligible population was also set to change over time, and the Centers for Medicare and Medicaid Services recently proposed to add a slate of additional providers to the program.

Overall, stakeholders and physicians have been supportive of the transition to MIPS and to value-based payments. In our third hearing, we heard from providers reaping the benefits and savings by participating in an Advanced Alternative Payment Model. That said, MACRA was not a sprint but a marathon and a viable fee-for-service model, in the form of MIPS, needed to exist. In continuing to follow MACRA implementation, certain decisions were made by the Center for Medicare and Medicaid Services that were for the benefit of a smooth transition, but had consequences that would have affected the agency’s trajectory of setting the performance threshold. Given this and other developments, I believed the law would benefit from some technical updates to improve the implementation of MIPS based on real-time factors. The Bipartisan Budget Act of 2018 included three MACRA technical fixes authored by myself along with Ranking Member Green, Representatives Roskam and Levin.

MACRA changed the world of Medicare provider payments as we knew it. It has laid the groundwork for increased access to quality care for beneficiaries by eliminating the uncertainty of the past, reducing physician burden, and providing incentives where there were none. MACRA was never a law that was going to be fully implemented with a flip of a switch, it was designed as a long term effort to move the Medicare program down the value continuum.

I want to thank all of our witnesses for joining us today. I look forward to hearing from each of you and learning more about how the implementation of this important law is progressing.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, for holding today’s hearing on the Medicare Access and CHIP Reauthorization, MACRA, and the merit-based incentive payment system, MIPS.

I also thank our esteemed panelists for joining us this morning.

The sustainable growth rate, SGR, was a thorn in the side of Medicare and doctors who treated Medicare patients for over decade after it was created in 1997. SGR’s formula led to a reduction of physician payments, starting in 2002, that had to be patched annually by Congress.

In 2014 and 2015, our committee, along with other committees with jurisdiction, came together and passed bipartisan legislation, the Medicare Access and CHIP Reauthorization Act, which permanently repealed the SGR. MACRA did more than just repeal the flawed SGR formula. It was designed to overhaul and realign payment incentives for Medicare and transition of our health system to one that rewards value instead of just the volume of care. MACRA provides civility to Medicare payments for providers for

the years immediately after the enactment and made it easier for providers to report on and deliver high-quality care.

Critically, MACRA encourages providers to move away from fee-for-service and participate in a new delivery model that would reduce costs while increasing quality. Under the law, physicians who treat Medicare beneficiaries have a choice between participating in MIPS or the advanced alternative to payment plan, APMs, to make the shift from fee-for-service and volume-based payment system to a value-based payment system. MIPS streamlined three prior quality incentive programs that were sunset in 2016 and have been replaced by a new MIPS category, quality, improvement activities, meaningful use, and cost.

Since starting in 2017, healthcare providers could choose whether to participate in APM or MIPS. Providers are exempt from MIPS if they fall below the low-volume threshold. For 2017, the Centers for Medicare and Medicaid set the low-volume threshold for providers who see fewer than 100 Medicare Part B patients or have less than \$30,000 in Part B charges annually. For 2018, CMS increased the low-volume threshold to \$90,000 in Part B charges or fewer than 200 Medicare patients per year. And for the next year, CMS has proposed maintaining the low-volume threshold for MIPS while adding a third exemption route for clinicians providing less than 200 covered services. CMS has proposed allowing clinicians who meet the exemption criteria to opt into MIPS.

Under MACRA, the Department of Health and Human Services is required to set the performance threshold by 2019 at the mean or median of final scores for all MIPS-eligible clinicians. In February, Congress passed legislation changing the timeline to ease the burden of the MIPS transition. The Bipartisan Budget Act of 2018 granted HHS an additional 3 years to ensure gradual, incremental transition to the mean or median of performance.

I look forward to hearing from our panelists regarding their experience with MIPS and recent changes made by Congress, whether additional action is necessary to ensure physicians participating in MIPS is generating savings to Medicare and improving patient outcomes.

Thank you, Mr. Chairman. I yield back my time. There is nobody on our side. So, I don't think they want any time.

[The prepared statement of Mr. Green follows:]

PREPARED STATEMENT OF HON. GENE GREEN

Mr. Chairman, thank you for holding today's hearing on the Medicare Access and CHIP Reauthorization Act (MACRA) and the Merit-Based Incentive Payment System (MIPS).

I also thank our esteemed panelists for joining us this morning.

The Sustainable Growth Rate (SGR) was a thorn in the side of Medicare and doctors who treated Medicare patients for over a decade after its creation in 1997.

SGR's formula led to a reduction of physician payments starting in 2002 and had to be patched annually by Congress.

In 2014 and 2015, our committee, along with other committees of jurisdiction, came together and passed bipartisan legislation, the Medicare Access and CHIP Reauthorization Act, which permanently repealed the SGR.

MACRA did more than just repeal the flawed SGR formula. It was designed to overhaul and realign payment incentives for Medicare and transition our health system to one that rewards value instead of just volume of care.

MACRA provides stability in Medicare payments for providers for the years immediately after its enactment and made it easier for providers to report on and deliver high quality care.

Critically, MACRA encourages providers to move away from fee-for-service and participate in a new delivery model that will reduce costs while increasing quality.

Under the law, physicians who treat Medicare beneficiaries have a choice between participating in MIPS or the Advanced Alternative Payment Models (APMs) to make the shift from fee-for-service and volume-based payment system to a value-based payment system.

MIPS streamlined three prior quality incentive programs that were sunset in 2016 and have been replaced by new MIPS categories: Quality, Improvement Activities, Meaningful Use, and Cost.

Starting in 2017, health care providers could choose whether to participate in an APM or MIPS. Providers are exempt from MIPS if they fall below the "low volume" threshold. For 2017, the Centers for Medicare and Medicaid Services (CMS) set the low volume threshold for providers who see fewer than 100 Medicare Part B patients or have less than \$30,000 in Part B charges annually.

For 2018, CMS increased the low volume threshold to \$90,000 in Part B charges, or fewer than 200 Medicare patients per year. And for next year, CMS has proposed maintaining the low volume threshold for MIPS, while adding a third exemption route for clinicians providing less than 200 covered services.

CMS has also proposed allowing clinicians that meet the exemption criteria to opt into MIPS.

Under MACRA, the Department of Health and Human Services is required to set the performance threshold by 2019 at the mean or median of final scores for all MIPS eligible clinicians.

In February, Congress passed legislation changing the timeline to ease the burden of the MIPS transition period.

The Bipartisan Budget Act of 2018 granted HHS an additional three years to ensure a gradual and incremental transition to the mean or median of performance.

I look forward to hearing from our panelists regarding their experience with MIPS, the recent changes made by Congress, and whether additional action is necessary to ensure physicians participating in MIPS are generating savings to Medicare and improving patient outcomes.

Thank you, Mr. Chairman. I yield the remainder of my time.

Mr. BURGESS. I thank the gentleman for yielding back. The gentleman does yield back.

There is 3 minutes left on the vote on the floor. We are going to recess until immediately after the vote on the floor.

[Recess.]

Mr. BURGESS. I call the committee back to order.

We are still waiting on the return of the ranking member and the chairman of the full committee, but anticipating that they will arrive, let's thank our witnesses for being here today and taking time to testify before the subcommittee.

Each witness is going to have the opportunity to give an opening statement, followed by questions from members. Today we will hear from Dr. David Barbe, the Immediate Past President of the American Medical Association; Dr. Frank Opelka, Medical Director, Quality and Health Policy, American College of Surgeons; Dr. Ashok Rai, Chairman of the Board, American Medical Group Association; Dr. Parag Parekh, American Society of Cataract and Refractive Surgery, and Kurt Ransohoff, Chairman of the Board, America's Physician Groups.

We appreciate you being here today, Doctors.

And, Dr. Barbe, you are now recognized for 5 minutes to give an opening statement, please.

STATEMENTS OF DR. DAVID BARBE, IMMEDIATE PAST PRESIDENT, AMERICAN MEDICAL ASSOCIATION; DR. FRANK OPELKA, MEDICAL DIRECTOR, QUALITY AND HEALTH POLICY, AMERICAN COLLEGE OF SURGEONS; DR. ASHOK RAI, CHAIRMAN OF THE BOARD, AMERICAN MEDICAL GROUP ASSOCIATION; DR. PARAG PAREKH, AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY, AND DR. KURT RANSOHOFF, CHAIRMAN OF THE BOARD, AMERICA'S PHYSICIAN GROUPS

STATEMENT OF DR. DAVID BARBE

Dr. BARBE. Chairman Burgess, Ranking Member Green, and committee members, thank you very much for the opportunity to come here today and to update you on the continuing implementation of MACRA.

I am a practicing family physician from rural southern Missouri, actually in Congressman Long's neck of the woods, and as you say, Past President of the AMA.

Physicians are familiar with value-based payment mechanisms. We have been subject to those for over 10 years, starting with PQRI, which was the original quality-based program. That was in 2007. Meaningful use came in in 2009. Value-based payments began in 2013. But each of these programs came in at separate times under separate bills, were never harmonized, never even contemplated working together. And all of them started as incentive programs, but most of them have transitioned into penalty programs which are additive.

As of now, a physician who is not able to perform, for whatever reason, in those programs could be subject to up to 11-percent negative adjustment in their Medicare reimbursement. That was simply not sustainable, and we thank you and the others that worked so hard on MACRA in 2015. That is a significant step forward. Not only did it repeal the SGR, as has been noted, but it began to harmonize these programs, bringing them under one administration, if you will, and it also reset, very importantly, the incentive and penalty corridor, such that for performance in the first year of 2017, it was a plus or minus 4 percent, certainly a better opportunity for physicians to succeed under that particular framework. So, we appreciate the work that went into that.

We share a common goal with you in seeing that these new quality payment programs are implemented appropriately, that the transition is smooth. Because we believe that the success of these programs has a real opportunity to improve quality for patients, to bend the cost curve. But, for them to be successful, physicians have to be able to succeed under these programs as well. Again, MACRA took us a significant step toward physician success and improving these programs.

In your opening remarks, you mentioned BBA 2018 and the significant improvements and technical fixes that were made. We really appreciated those as well. We will continue to work closely with you because, as you also suggested, this wasn't a one-and-done. This is an evolving process. And hearings like this today, allowing us to update you, are critical in continuing to improve that process for patients, physicians, and for the Medicare program.

As a part of the BBA 2018, we strongly support the Part B drug cost exclusion. We support flexibility for CMS to re-weight the cost performance measures. We appreciate the performance threshold flexibility that you gave CMS. We need now for CMS to use the flexibility that you gave them to make this transition appropriate. So, we will continue to work with them. We have made multiple suggestions already, and we will continue to try to make this transition appropriate.

One of the other pretty important parts of what you enabled was for PTAC to consult with physician groups as we develop physician-focused payment models. The PTAC has been doing what you have wanted it to do. They have received dozens of proposals, and they have even recommended about 10 of those onto CMS. Unfortunately, CMS has not seen fit to adopt any of those yet, and I think it is thwarting the creativity and innovation that physicians are willing to bring to the table. So, we will continue to work with CMS to try to get them to consider and adopt some of those alternative payments models that are physician-focused that PTAC has recommended.

And I think, lastly, you may hear some discussion today about the limitation of the upside opportunity to something in the 2-percent range, rather than the 4 percent that was originally contemplated. Again, the goal is to help physicians succeed. All of the organizations represented here represent a wide range of physician practices, physician styles. The AMA certainly does. We represent physicians from all specialties, all practice types.

It is critically important that all those physicians have an opportunity to succeed under this program. Whether you are a large megagroup like the one I am in or whether you are a single, independent physician practicing someplace else in Missouri, you need an opportunity. And so, CMS needs flexibility. We need a smooth transition, and we really appreciate the continued opportunity we have to dialog with you on this.

[The prepared statement of Dr. Barbe follows:]



Statement

of the

American Medical Association

to the

**U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health**

**Re: MACRA and MIPS: An Update on the Merit-based Incentive
Payment System**

July 26, 2018

**Division of Legislative Counsel
(202) 789-7426**

STATEMENT

of the

American Medical Association

to the

U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health

Re: MACRA and MIPS: An Update on the Merit-based Incentive Payment System

July 26, 2018

The American Medical Association (AMA) appreciates the opportunity to present our views to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health. As the largest professional association for physicians and the umbrella organization for state and national specialty medical societies, the AMA is heavily invested in the successful implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Since the enactment of MACRA, we have worked closely with policymakers and the Centers for Medicare and Medicaid Services (CMS) to ensure that implementation of the law reflects the intent of Congress to focus on improving quality and value, and that physician practices are able to successfully participate. We remain committed to working with both Congress and CMS to promote a smooth implementation of the Quality Payment Program (QPP) that will allow physicians to be successful.

We continue to believe that MACRA, and more specifically the Merit-Based Incentive Payment System (MIPS), represents an improvement over the flawed sustainable growth rate (SGR) payment methodology and the three legacy reporting programs it replaced: the Physician Quality Reporting System (PQRS), Meaningful Use (MU), and the Value-Based Payment Modifier (VM). We recognize that the MIPS program is still in its initial stages and must continue to be improved and simplified. We commend Congress for the 2018 statutory improvements to the MACRA law which extends CMS' flexibility to set the performance threshold and reweight the cost performance category for an additional three years. We also appreciate Congress' clarifications that Medicare Part B drugs are not included in the incentive and penalty payments for the MIPS program. While we believe these changes strengthened the MIPS program, we are committed to continuing to work with the CMS and Congress to further improve the program.

Improvement Over Legacy Programs

The AMA was supportive when Congress replaced the flawed, target-based SGR formula with a new payment system under MACRA in 2015. Due partially to the fundamentally flawed concept of the SGR – namely that the threat payment cuts for all physicians would serve as an individual incentive to limit volume growth – and partially to the failure of Congress to do more than temporarily block cuts, scheduled payment cuts prior to the implementation of MACRA

exceeded 20-percent. Those cuts would have had a devastating impact on physician practices and beneficiary access to care. Under MACRA, the SGR formula was replaced with specified payment updates for 2015 and beyond. MACRA also created an opportunity to address problems found in existing physician reporting programs (i.e., PQRS, MU, and VM). In addition, the law sought to promote innovation by encouraging new ways of providing care through APMs.

MACRA was designed to offer physicians a choice between two payment pathways: a modified fee-for-service model, MIPS, or new alternative payment models that support high value services, including those not typically covered under the Medicare physician fee schedule, or APMs. While MIPS is complex, it represents an improvement over the prior reporting programs. For example, under prior law, possible combined penalties for the PQRS, MU, and VBM programs could be up to negative 11 percent in 2019 based on 2017 reporting, and PQRS did not offer an opportunity to earn an incentive. Under MIPS, the maximum penalty physicians can receive in 2019 is negative four percent based on 2017 reporting. The maximum penalty increases to negative nine percent in future years, which is at least two percentage points less than the possible penalties under legacy reporting programs. Also, there is a potential for bonus points for high performers under MIPS.

Furthermore, the AMA supports the accommodations for small practices that are included in the MIPS program. Specifically, the low volume threshold exemption excludes numerous small practices or physicians who see very few Medicare patients. In 2018, physicians with annual Medicare allowed charges of \$90,000 or less or 200 or fewer Medicare patients, are exempt from the QPP altogether. In 2019, CMS proposes to also exclude physicians who provide 200 or fewer covered professional services to Medicare Part B beneficiaries. The AMA has also supported reduced reporting requirements for small practices, hardship exemptions from the Promoting Interoperability MIPS performance category for qualifying small practices, bonus points for small practices, and technical assistance grants to help small practices succeed in the program. Among small practices that are not exempted by the low volume threshold, CMS estimates that 91 percent of eligible professionals in practices of one to 15 physicians will experience a positive or neutral payment adjustment in 2020 based on 2018 reporting. The AMA believes this is a notable improvement over the barriers small practices faced in previous reporting programs.

Each performance category under MIPS also contains improvements over the legacy reporting programs. For example, in the Quality performance category, physicians are required to report six measures as opposed to the nine they were required to report under PQRS, and they can now receive partial credit for reporting fewer than six measures. CMS' recent proposals for the Promoting Interoperability performance category in 2019 eliminate the base and performance categories and reduce the number of required measures, many of which were problematic for physicians as they led to physicians being scored based on the actions of others. In the Cost category, CMS has been working to develop a new suite of episode-based measures, the first eight of which they propose for use during the 2019 performance period.

Physicians participating in APMs also benefit under MACRA. While there are currently a limited number of Advanced APMs, physicians participating in these models will receive a five percent bonus payment for the first six years of the program. MACRA also allows favorable treatment for qualified medical homes as Advanced APMs and in the MIPS Improvement

Activities category. In addition, certain APMs, such as Track 1 accountable care organizations in the Medicare Shared Savings Program, are defined as MIPS APMs and allow their physician participants to meet their entire MIPS reporting requirements through their APM participation. The AMA strongly supports the development of additional APMs to offer more patients and physicians the opportunity to participate in models that help reduce costs and improve the quality of health care.

Support for Technical Corrections

The AMA strongly supports the changes to MACRA in the Bipartisan Budget Act of 2018 (BBA18). We believe these technical changes to the statute will help simplify and improve the MIPS program. Since the enactment of BBA18, CMS released the *Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for 2019; Medicare Shared Savings Program* proposed rule. We are in the process of thoroughly evaluating the proposed rule and will be submitting our comments to CMS by the September 10 deadline.

We commend Congress for excluding Medicare Part B drug costs from MIPS payment adjustments. Including these additional items and services created significant inequities in the administration of the MIPS program. Although in the past CMS included Medicare Part B drugs in the calculation and comparison of physician costs under the VM, none of the legacy programs applied adjustments to reimbursement for the drugs. Excluding Medicare Part B drug costs from MIPS payment adjustments eliminates a significant departure from previous policy that could have penalized some physicians whose patients require high-cost Part B drugs and created a potential windfall for others whose patients can be treated with less costly drugs. This policy also would have underpaid physicians for the cost of acquiring drugs if they received a low MIPS score, and overpaid them if they received a high MIPS score. We also commend CMS for proposing to implement the revised Part B drugs policy beginning in 2019.

We also appreciate the flexibility given to CMS to reweight the Cost performance category to not less than ten percent for the third, fourth, and fifth years of MIPS. We agree that, while development of resource use measures is an ongoing effort, more time is needed to test them and make any necessary changes. Unlike the program's quality measures there was no physician input in the development and review of resource use measures prior to the enactment of MACRA. The AMA strongly supported additional flexibility for CMS to reweight the Cost performance category and believed that allowing three additional years for the cost score to be weighted at less than 30 percent would allow additional time for CMS to build on its ongoing initiative to utilize panels of physicians to develop, test and refine resource use measures. We are concerned, however, that CMS is proposing to increase the Cost category score to 15 percent in the 2019 performance period, given that 2019 is the first year it is testing eight newly developed episode-based cost measures. We question whether proposal does not align with Congress' intent to keep the weight of the Cost performance category low until episode-based cost measures are adequately tested and available for a variety of physician specialties, and will be providing comments to CMS to this effect.

In addition, we strongly support the ability for CMS to exercise flexibility in setting the

performance threshold for three additional years. Physicians are still becoming familiar with the MIPS program, and allowing CMS three additional years of flexibility in setting the performance threshold will help smooth the transition to a performance threshold at the mean or median. As Congress intended, we believe the goal of the program should be to help doctors succeed, not to cause doctors to fail. In the proposed rule, CMS is proposing to double the performance threshold from 15 points in 2018 to 30 points in 2019. While the 30 point performance threshold is likely lower than the mean or median for 2019, we continue to urge CMS to use the flexibility provided by Congress to increase the performance threshold very gradually during the first five years of the program.

Finally, we strongly support the ability for the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to provide initial feedback on proposed APM models regarding the extent to which they meet criteria and an explanation of the basis for the feedback. With the creation of the PTAC, Congress sent a strong signal to HHS and CMS that implementing physician-developed APMs is a critical element of the transition to value-based payment models for Medicare patients. Therefore, we are extremely concerned that none of the APM models recommended by PTAC to the Secretary of the U.S. Department of Health and Human Services (HHS) have been tested or implemented to date. We are particularly concerned given that the MACRA statute only provided six years of bonus payments to facilitate physicians' migration to Advanced APMs, yet we are approaching the three-year mark for the initial implementation and there is still not a robust APM pathway for physicians. See our [recent letter to HHS](#) for more details on our concerns.

Further Improvements are Needed

CMS has also proposed numerous policies that the AMA strongly supports. For example, we support the addition of a third criterion of providing fewer than 200 covered professional services to Part B patients for physicians to meet the low-volume threshold, and the ability of physicians to opt-into the MIPS program if they meet fewer than three of the low-volume threshold determinations. We also support the retention of bonus points for small practices and physicians who treat complex patients. We believe CMS' proposal to consolidate the low-volume threshold determination periods with the determination periods for identifying a small practice, non-patient facing physicians, and hospital-based physicians will reduce confusion and program complexity. We also commend CMS for eliminating the performance and base scores, reducing the number of measures physicians must report on, and providing physicians more flexibility in the Promoting Interoperability performance category. Furthermore, we support the option for facility-based physicians to use facility-based scoring in the Quality and Cost performance categories beginning in 2019. Finally, we were very pleased to see CMS propose the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration and strongly support allowing physicians participating in risk arrangements in MA similar advantages to those enjoyed by physicians participating in traditional Medicare APMs.

While we commend CMS for these proposals, we also believe there are numerous additional improvements that can further simplify MIPS and help physicians succeed in reducing health care costs while improving health care quality. Our overarching goals in shaping MACRA regulations continue to be choice, flexibility, simplicity and feasibility.

For example, there are several steps CMS can take now to simplify the overly complex scoring system including harmonizing the scoring across the four separate components of MIPS so that physicians can more easily calculate their progress toward achieving success and increasing opportunities for physician reporting to be counted across multiple categories in a more coherent payment system.

CMS should also change Promoting Interoperability reporting requirements to attestation alone and develop new measures that utilize not only certified electronic health records (EHRs), but also technology that builds on certified EHRs.

Furthermore, the AMA has strongly urged CMS to move away from the siloed, check-the-box legacy programs to a single program that is more holistic and clinically relevant. Specifically, the AMA has worked with state and specialty medical societies to develop a proposal that would allow physicians to focus on activities that fit within their workflow and address their patient population needs, while receiving credit for those activities across multiple MIPS performance categories.

In addition, there are further changes to the program that would reduce physicians' administrative burden, including reducing the number of quality measures a physician is required to report within the Quality performance category and allowing physicians the option to report for a minimum of 90-days in all performance categories to better align reporting periods. CMS should also expand the facility-based definition to provide physicians in settings such as post-acute care facilities and long-term care facilities a meaningful way to participate in MIPS. Our recommended changes would reduce physicians' administrative burden, allowing them to spend more time with their patients.

The AMA remains committed to ensuring that the MACRA program is successful. We appreciate the opportunity to provide our comments on the current MACRA program, and we look forward to continuing to work with the Committee and CMS to make further improvements.

Mr. BURGESS. Thank you, Dr. Barbe.
 Dr. Opelka, you are recognized for 5 minutes, please.

STATEMENT OF DR. FRANK OPELKA

Dr. OPELKA. Chairman Burgess, Ranking Member Green, members of the committee, on behalf of the 80,000 members of the American College of Surgeons, we appreciate the invitation to share our thoughts with you today.

The American College of Surgeons again expresses our thanks to Congress for the aspects of MACRA which have eliminated the sustainable growth rate and led to efforts designed to link payment more closely to quality and value. Congress' efforts have not only reduced maximum penalties, your efforts seek to phase in new incentives and provide potential for positive updates. Particularly noteworthy are the congressional efforts to combine and simplify value-based goals for measuring quality improvement. After all, we measure, so that we can improve, not just get paid. We also appreciate the congressional directives for moving from fee-for-service to alternative payment models. We would wish CMS would improve their efforts to work with the American College of Surgeons', ACS, physician-focused payment model. We are mindful of Congress' interest in oversight of CMS's implementation of MACRA.

In order for clinicians to assume risk in value-based payment programs, physicians must have reliable and valid measures of both quality and the cost of care. The American College of Surgeons seeks to support the congressional intent of MACRA through our work product for building meaningful quality measures for surgical patients and surgeons, as well as proffering the CMS our APMs which are based on true total cost of care.

The American College of Surgeons began over 100 years ago, when America had more hospitals than we have today. They were small and care was not standardized. To standardize quality, we formed the College of Surgeons, and we created the first hospital accreditation. In later years, this became The Joint Commission. Today, we continue those verification programs in order to promote standards for quality of care in trauma centers, such as Level I, Level II, and Level III trauma centers.

Neither the Federal Government nor commercial payers do much to recognize the over 200 quality standards we create to maintain a national trauma system for this country. Our verification programs are a model which measure what matters to patients. We measure the team and the totality of care. We worry less about measuring the individual surgeon and focus more about measuring the outcome to patients. We, then, credit the entire team with its successes and we use the knowledge gained from our programs to create learning networks which teach others and spread improvement widely, none of this recognized in payment programs.

In much the same way, we have created cancer verification, breast care verification, bariatric care, pediatric surgical care, and now more. Yet, CMS offers meaningless measures which do little to help the surgical patient. CMS feels constrained from measuring team-based measures, instead seeking simply constructed measures such as surgeons having to track patients' immunizations, rather than measuring the surgical team. The end result is meas-

ures become meaningless, burdensome, and distractions. Hospital CEOs end up defunding valued surgical quality programs to chase the wrong measures, simply because that is how they get paid.

It is time we, as the American College of Surgeons, seek congressional directives for CMS to build a strong surgical quality program for each major surgical domain, just as the College has done in our team-based models for hospitals for trauma, for cancer, and more. It is time that we measure what matters. It is time for payment models to align with clinical care and not force clinical care to conform to payment.

Lastly, the American College of Surgeons serves as a leader in digital information and health IT. We are focused on patient-centered digital records, not just EHRs, since patients' lives exist in more than one EHR. This calls for an expansion of our thinking beyond EHRs into a world of interoperability, connecting patients across EHRs, across smart devices, across clinical registries, for activities such as clinical decision support, machine learning, and artificial intelligence. There is so much more we can do for quality and for lowering cost by leveraging digital information. We have to stop thinking of EHRs and think beyond them. We could use your support in promoting this level of interoperability to make an interoperable digital patient medical record. We look forward to working with the Congress to help surgeons care for patients.

Thank you very much.

[The prepared statement of Dr. Opelka follows:]



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**AMERICAN COLLEGE
OF SURGEONS**

*Inspiring Quality:
Highest Standards,
Better Outcomes*

**Statement of the
American College of Surgeons**

Presented by

Frank Opelka, MD, FACS

**before the
Subcommittee on Health of the
Committee on Energy and Commerce
United States House of Representatives**

**MACRA and MIPS:
An Update on the Merit-based Incentive Payment System**

July 26, 2018

Chairman Burgess, Ranking Member Green, and Members of the Subcommittee, on behalf of the more than 80,000 members of the American College of Surgeons (ACS), I wish to thank you for inviting our participation in this hearing. ACS has a long-standing commitment to improving the quality of care for the surgical patient. This commitment extends to ensuring that the ongoing implementation of the *Medicare Access and CHIP Reauthorization Act (MACRA)* is accomplished in a way that improves the delivery of medicine for patients and removes administrative burdens on physicians. This is a critical time in the process of implementing the law and CMS would benefit not only from additional guidance from the physician community, but also from the committees in Congress who conceived the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) pathways to restate the vision of that bill and refocus on Congress' original intent. We welcome this opportunity to share our experience, our impressions of the MIPS program thus far, and suggestions on how to make the program more meaningful for patients and physicians through implementation.

ACS' understanding at the time of passage of *MACRA* was that surgeons and other physician specialties would be evaluated based on measures related to the care they provide and would have access to APM options suitable to their practice. If these were unavailable at the time of passage, opportunities were built in by Congress to allow specialties to develop them. However, these new models and measures have not materialized, and not for lack of effort on the part of the physician community. ACS has, for years, sought to be a partner in developing solutions to the most complex challenges facing Medicare. This includes efforts to develop

innovative payment strategies as part of a replacement for the sustainable growth rate (SGR) as well as more recent work to create APM options for surgeons and other providers and new tools for participants to improve care for Medicare patients.

I would like to thank Congress for eliminating the Sustainable Growth Rate (SGR) and designing a program intended to tie payment more closely to quality and value. It is easy to forget the challenges faced prior to *MACRA* in the face of ongoing implementation efforts. There are a number of positive concepts to be noted in *MACRA* beyond the elimination of the much-maligned SGR cost control formula that were aimed at addressing these challenges. These include:

- Overall reduction of maximum penalties associated with PQRS, VM and EHR-MU from 10+ percent in 2016 to five percent this year and growing to a maximum of nine percent over time.
- Incorporation of a meaningful potential for positive updates. Prior to *MACRA*, penalties from PQRS and EHR-MU were lost from the physician reimbursement pool. Under *MACRA* these funds stay in the pool and are used to provide positive payment adjustments for high achievers. While we strongly believe there is a need for realistic updates to the physician fee schedule, we welcome the much greater upside potential. Surgeons, like all humans, are risk averse and reward focused. As such, we believe an asymmetrical risk profile with greater upside potential is more likely to incentivize behavioral change.
- Goal of combining and simplifying existing programs into a single streamlined program. We also recognize the focus on quality as witnessed by the weight

ascribed to both Quality and Improvement Activities. Continued physician input is essential to merge quality measurement and improvement activities seamlessly into the clinical care model.

- Goal of moving from fee-for-service to APMs as well as a pathway to develop new models. While we greatly appreciate this provision and have taken advantage of the Physician-focused Payment Model Technical Advisory Committee or (PTAC) pathway to propose a new model, we feel that more could be done to expedite testing of models once they have been recommended. To date, none of the models recommended by the PTAC have been implemented or even tested by the Center for Medicare and Medicaid Innovation (CMMI).
- Inclusion of additional incentivizes for the highest performers in MIPS as well as early APM adopters.

Congress showed foresight in providing a period of stability in the original *MACRA* legislation, and we commend Congress for extending this flexibility in the *Bipartisan Budget Act of 2018* (H.R. 1892) in recognition of the difficult task faced by CMS in implementing this program, and by physicians in educating themselves and changing their practices as necessary to meet the new requirements. To be clear, ACS plans to make good use of this opportunity to advise CMS on how best to measure quality for surgeons. If we are putting providers at risk based on these metrics, we must ensure that the appropriate physicians are being rewarded or penalized. We see this new discretion being used by CMS in the recently proposed rule to implement the QPP for 2019 in several areas including the cost portion of MIPS and the setting of the

threshold for the Final Score payment adjustment determinations.

Congress has now made the transition from its legislative role to one of oversight to ensure that the *MACRA* law is being implemented in the best interest of Medicare patients, as you all intended. This is important because unfortunately, we have reason to be concerned that actions taken by CMS since the passage of *MACRA* may not be sufficient to take us to our shared end goals. While some of these actions may have been well intentioned and taken in the name of reducing reporting requirements or reducing overall burdens of participation, others seem counter to the very spirit of the law, such as the failure to move forward on any of the APMs reviewed by the PTAC. We need Congress' help to ensure the law is implemented correctly so that physicians who are providing high quality, high value care to their patients are able to succeed. We believe CMS needs additional guidance from Congress at this point to ensure the intent of moving the physician payment system toward quality and value is upheld.

Implementation of the MIPS program needs to be refocused to better achieve some of these intended goals. ACS would like to lend our century of experience in setting standards for surgical quality to that end. This history includes founding what is now referred to as the Joint Commission and creation of accreditation programs such as that used to verify trauma centers and quality improvement efforts such as the National Surgical Quality Improvement Program (NSQIP). We believe this experience may assist CMS with creating novel ways to improve the accuracy and validity of quality measurement while continuing to tackle unnecessary burdens on physicians.

Achieving the Goals of MIPS

To reiterate, the underlying concept of MIPS was to simplify the existing CMS quality programs, combine them into a single program that compares the value of care provided by participants (as judged based upon quality and cost metrics, use of electronic health records and improvement activities) and adjusts payments up or down based on that comparison.

As originally envisioned, the idea was to provide physicians with a period of stability after repeal of the SGR and its threatened reimbursement cuts, during which time CMS would develop the regulations to implement the new payment system and physicians could adapt their practice to meet the new requirements. The new program would then be gradually phased in over several years with certain additional incentives (such as an additional pool of money for bonus payments to early APM adopters) available in the early years of the program. The amount of money at risk for providers would gradually grow to nine percent, which was comparable to (but slightly less than) the maximum combined penalties associated with the Physician Quality Reporting System (PQRS), Value Based Modifier (VM), and Electronic Health Record Incentive Program (EHR-MU) programs. Unlike the prior programs however, MIPS has the potential for equivalent positive payment adjustments. Since payment adjustments are largely budget neutral and few physicians were penalized during the first transition year, we have not seen the positive updates of four percent for 2019 equivalent to the maximum four percent penalty for that year. This is due to low volume exclusions and favorable "pick-your-pace" policies which made it relatively straightforward to avoid penalties during the transition period.

Given the complexity of the underlying PQRS, VM, and EHR-MU, and the extremely diverse and broad range of physicians to be evaluated and compared, simplification has proven to be

a daunting task. Providing physicians with credit for their efforts to improve their clinical practice, while worthwhile, further adds to this challenge.

While Congress' goals surrounding the aforementioned policies were laudable, and while we acknowledge that CMS' resources are limited, the implementation of this new payment system is taking longer than anticipated in some areas, especially in the crucial development of new quality and cost measures. The first funding opportunity for measure development was delayed until this year and funds allocated in *MACRA* for the development of new quality measures have still not been awarded for this purpose. Similarly, the development of accurate, episodic cost measures is proving both difficult and time consuming. Currently cost measurement is based solely on legacy total cost of care measures.

Surgeons support being held accountable for the quality of care received by their patients. It is, however, essential that efforts to do so are accurately measuring quality in a way that can lead to improvement and which does not overburden providers, inadvertently taking their focus away from the patient. To accomplish this, CMS needs measures that accurately and meaningfully target the episode of care being assessed, providing useful information to physicians and patients. This is not currently the case. For example, surgeons are frequently being evaluated based on a patient's immunizations. This is not relevant to the care surgeons provide, and therefore is seen as unnecessary and burdensome. This in turn reflects poorly on MIPS and its intention, causing a lack of buy-in on the part of many surgeons. This buy-in on the part of all physicians will be necessary if MIPS is to be successful in its goal of improving quality and value in health care; otherwise it will simply be seen as a new set of burdensome boxes to check as part of a payment program. Unfortunately, this focus on check-the-box

measures to maximize reimbursement will have the unintended consequence of crowding out quality programs that truly improve care to the patient. This is most certainly not aligned with the Congress' intent when *MACRA* was passed and the ACS is committed to working with Congress to ensure CMS prioritizes meaningful measure development for all specialties moving forward.

Measuring Quality in Surgery

Surgeons and surgical patients are best positioned to understand what elements of care are important to measure in order to evaluate the quality of care and provide the information needed for improvement. As noted above, surgical quality measurement in MIPS is seen by many as poorly representing surgical care. Measures reported by large groups are typically related to primary care or are population-based measures that are not at all related to the care surgeons provide. These measures can be complex, burdensome, and frustrating as it takes time and resources away from other efforts that could have a greater impact for patients. Unfortunately, that means that what affects payment is not directly related to what affects quality, as Congress intended.

ACS has taken advantage of the additional flexibility granted recently by Congress to further develop our thoughts on how best to measure surgical quality in a way that is accurate. The right measures for quality and improvement, no matter how complex, are never burdensome. It is meaningless measures, such as many of those currently reported to CMS, which are burdening care teams.

We have proposed to CMS that surgical quality measurement should include a combination of three elements: standards-based facility-level verification programs, patient reported experience and outcomes measures, and traditional quality measures such as those currently in MIPS, including registry and claims-based measures. Combining these three elements will provide a much clearer picture of the quality of care provided to the patient, including not just the surgeon, but the entire care team involved. The verification programs used have a long history of success, including the Joint Commission and ACS' Trauma, Bariatric, and Cancer accreditation programs.

We wish to draw attention to ACS' Verification, Review, and Consultation (VRC) program for trauma verification as a model program. We have developed and offer trauma verification and review consultations to assist trauma centers in the evaluation and improvement of trauma care. Using the *Optimal Care of the Injured Patient* as a guide, the VRC validates resources at trauma centers with the goal of assisting a trauma center to attain a designated level of service – Level I, II, or III. To achieve the highest recognition, Level I, means the trauma facility must meet or exceed more than 200 clinical standards for optimal care. Who, if seriously injured, does not want to seek care at a Level I trauma unit? Thousands of lives have benefited from these trauma verification standards, with only limited recognition from CMS, the federal government, or commercial insurers.

These verification programs are proven to measure quality and to drive improvement. We are currently developing pediatric trauma care and geriatric trauma care verification programs as well. It is time the US Congress and the ACS come together to set expectations from CMS

and our commercial insurers which leverages standards in verification programs for all aspects of surgical care such as cancer, bariatrics, cardiac care, orthopedics, and so forth.

The importance of setting standards at the facility level to achieve quality outcomes cannot be overstated. Our experience tells us, if you put a surgeon with the highest technical skill level into an underperforming environment where the resources needed are not available and systems are not in place to protect the patient, that surgeon will struggle to provide the highest quality care. Conversely, if you put an average surgeon in a great system, their outcomes are likely to improve and patients will receive better, more coordinated care. ACS' recently published manual, entitled *Optimal Resources for Surgical Quality and Safety*, describes key concepts for developing standards in quality, safety, and reliability, and explores the essential elements that all hospitals should have in place to ensure patient-centered care. Publication of the *Optimal Resources for Surgical Quality and Safety* further reinforces ACS' commitment to high-quality and coordinated care.

To compliment the verification program, patient reported outcomes or PROs are important to validate, from the patient directly, that their personal goals for their surgical care were met. PROs represent the views and perceptions of patients and can be extremely useful in improving patient care. These measures are the mainstay in the promotion of patient-centered care.

Finally, our quality model includes traditional claims-based measures to be aggregated with limited burden, primarily as an additional check to verify that quality care is being delivered. If the correct measures are selected, they can be seen as informative and meaningful to physicians, not burdensome. It is important to ensure that collection of these data enhances

patient care rather than taking the focus away from what is important. Many existing measures, including outcome measures, are not sufficient on their own for measuring the quality of care provided.

Due to decades of continuous quality improvement efforts, there is little variation in outcomes for many surgical procedures as judged by existing outcome measures. In fact, there is so little variation that use of these measures is statistically not valid in many cases due to the large sample size that would be needed. Instead, attaining high quality care through a combination of ensuring that standards are being achieved and validating outcomes through measuring the patient's perspective on whether goals of care and other milestones are being achieved may be more reliable.

Promoting Interoperability

For many providers, Promoting Interoperability (PI) remains the most frustrating aspect of the MIPS program. The category is focused too narrowly on the EHR and less on the advancement of broadly applied patient digital health information from all data sources as the original name of "Advancing Care Information" implies. In implementing MIPS, CMS should have a laser focus on making sure that a complete view of a patient's digital health information is available to physicians, in a useful, standardized form, when it matters most. A patient's longitudinal care profile rarely exists in a single EHR. Physicians need a digital health information environment which represents the patient with enabling information from EHRs, smartphones, iPads, tablets and other available sources. The passage of *MACRA*, along with the recent removal of the counterproductive requirement that EHR meaningful use standards grow ever

more stringent over time (a provision of the aforementioned *Bipartisan Budget Act*) have created an opportunity to reimagine what constitutes meaningful use.

When the *HITECH Act* was originally enacted, meaningful use was intended to be a means to validate that Congress' investment on EHRs was spent wisely. The resulting program therefore focused on the meaningful use of specific, Certified EHR technology or CEHRT required by the program. The federal government is no longer subsidizing adoption of this technology however, and ACS believes that we should take this opportunity refocus to the original goals of using technology, and more specifically digital health information at the patient level, to improve care and lessen the focus on EHRs alone. PI should focus on who is using digital health information to build a more complete patient record that is available to patients and physicians at the point of care, and how they are using this information to improve the quality and efficiency of care. The ACS looks forward to working with Congress, CMS, and the Office of the National Coordinator (ONC) to help create a digital health information environment that achieves these goals.

Development of Alternative Payment Models

One aspect of the law where ACS has seen both great promise and significant frustration is in the area of APMs and specifically the potential for new physician-focused models. The incentives included in *MACRA* made it clear to the ACS that an underlying goal of the legislation was to incentivize the creation of and move to APMs and Advanced APMs (A-APMs). These incentives include the five percent lump sum bonus for qualified A-APM participants for the first six years of the QPP, the reduced reporting requirements potentially associated with these models and higher updates to the conversion factor for APM participants

than those in MIPS in later years. *MACRA* also included a new pathway for APM development in the PTAC. ACS saw the value of creating such a model and was the first organization to submit a proposal to the PTAC. Our experience with the process was smooth and helped greatly in refining our model (known as the ACS-Brandeis Advanced Alternative Payment Model) and our thinking on APMs, as well as informing our positions on quality and cost measurement in team-based health care. However, there appears to be a disconnect with the PTAC recommendation process compared to the testing of new models by CMS.

To date, the PTAC has received more than 20 proposals and reviewed and made recommendations on 15 models. Of these, 10 were recommended to the Secretary of Health and Human Services for either limited scale testing or implementation. Yet despite all of this work on the part of the PTAC and the organizations who have developed these proposals, none of the recommended models have been tested or implemented by CMS. In fact, Secretary Azar recently declined to move forward on testing of eight of these PTAC-recommended models in a single letter. While we feel there is great merit in the move toward APMs, and plan to continue work on developing core concepts of the ACS-Brandeis A-APM, it is unfortunate that the input from the broader health care community is being largely ignored.

Given the challenges noted previously from the perspective of our specialty, as well as those noted by others, it may be invaluable to commission a study on these challenges, including CMS' ability to measure the true quality of care provided by physicians of all specialties, the availability of cost measures that are meaningful and actionable in concert with these quality measures, physicians' ability to access patient health information when they need it and in a standardized predictable format, and the availability of APMs that grant physicians of all

specialties the opportunity to be creative in using their expertise to increase quality and value of care to the patient.

I, and the ACS, appreciate the opportunity offered by the Chairman, Ranking Member, and the committee to testify at this hearing. *MACRA* and MIPS should be seen as an opportunity for ongoing and iterative improvement in how physicians are paid under Medicare, and more importantly, on how quality in medical care can be incentivized. This hearing represents an important example of congressional leadership and oversight to ensure that the promise of the new law and the new payment system are achieved. We look forward to continued partnership in improving the quality of care enjoyed by Medicare patients.

Mr. BURGESS. Thank you, Doctor.
And, Dr. Rai, you are recognized for 5 minutes, please.

STATEMENT OF DR. ASHOK RAI

Dr. RAI. Chairman Burgess, Ranking Member Green, and distinguished members of the Energy and Commerce Committee on Health, thank you for the opportunity to testify today.

I am Dr. Ashok Rai, and I am here today as Chair of AMGA, which represents multi-specialty medical groups and integrated delivery systems. Our membership provides care for one in three Americans.

I am a board-certified internist with 17 years of experience, providing care to patients in Green Bay, Wisconsin. Since 2009, I have served as the President and CEO of Prevea Health, a multi-specialty medical group which employs more than 350 providers, including 60 medical specialties. In total, we employ more than 2,000 people, and I am proud of the impact we have on the people of Wisconsin.

I wanted to express my appreciation to Congress for repealing the SGR formula for Medicare Part B payments. The annual SGR cliffs were obstacles to sound planning and hindered our ability to make strategic decisions that would help us care for patients.

I applaud the committee's leadership role in passing the much-needed MACRA law which puts providers on a path towards value-based care. We agree with Congress that the current fee-for-service payment system is not sustainable, nor is it good for our patients. We need to move to a system where the payment aligns with the way medical groups focus on the health of a population, rather than only the sickness of patients.

Under MACRA, CMS combined existing programs such as the physician quality reporting system, the value-based modifier, and meaningful use programs to create the merit-based incentive payment system, better known as MIPS. Under the MACRA statute, MIPS providers would have the opportunity to have positive or negative payment adjustments based on their performance, starting at plus or minus 4 percent in 2019 and eventually plus or minus 9 percent in 2023.

By putting provider reimbursement at risk, I believe Congress intended to move Medicare to a value-based payment model where high performance was rewarded and poor performers were incented to improve with lower payment rates. In fact, high-performing groups like Prevea Health have been preparing for this value transition for years by participating in MIPS's legacy programs such as PQRS, VM, and MU. As a result, our efforts to perform in these legacy programs have improved the value of care provided through increased quality and decreased cost.

But the problem we face now as healthcare providers is that CMS is excluding a majority of providers from the MIPS program. CMS has bypassed the intent of MACRA by excluding 58 percent of providers from MIPS requirements for performance year 2019 and the recently-proposed quality payment program, or MACRA rule. This will result in the 2021 payment year adjustment being around 2 percent for high-performers, instead of closer to 7 percent, which the statute dictates. Last year, CMS excluded 60 percent of

eligible clinicians, which collapsed the potential reward for high-performers from 5 percent to 1.5 percent.

To give you a real-life example of how this works, in the four Tax Identification Numbers that Prevea Health bills under in partnership with our hospital partners, Hospital Sisters Health System, Prevea Health scored three perfect scores of 100 and one of 97. However, because of the MIPS exclusions, our payment adjustment was only 2 percent. Why is this important? To get to value, to create change is incredibly difficult. It requires changes in how we deliver care, how we set up our administrative and financial processes. It means investing millions of dollars in information technology and people. Importantly, it requires buy-in from every member of the team, especially the providers.

The changed management challenges presented by creating a new value-based delivery system are enormous. And Prevea Health undertook this challenge because we viewed MACRA as the incentive program that would reward us for making these changes and doing well by our patients. Now, though, I have to go back to the physicians and providers at my group and say the investments we made, they weren't rewarded. The better care we delivered was not recognized. That is a difficult message to deliver, and I don't think that is the message that this committee or Congress wanted us to make, but it is the one we have to tell providers at Prevea because of the way MACRA is being implemented.

I appreciate the concerns so ably expressed today by my colleagues for physicians practicing in solo or smaller practices. The reporting burden on them is real. However, I have to point out that the MIPS program is a continuation of quality programs that have been in existence for years, and no one is excluded from these programs, certainly not 58 percent of them. I firmly believe Congress passed MACRA to push the transition to value in Medicare Part B. Ironically, by excluding the majority of clinicians from MIPS, if anything, we have taken a step back from this transition. These exclusions need to end. Only then can MACRA meet your goal of moving Medicare meaningfully towards value. AMGA stands ready to work with Congress and CMS to ensure MIPS, and MACRA, serves as the transition tool to value, as it was intended to be.

Thank you.

[The prepared statement of Dr. Rai follows:]

Statement of
Ashok Rai, M.D.
President and Chief Executive Officer, Prevea Health
On
MACRA and MIPS: An Update on the Merit-based Incentive Payment System
Before the Subcommittee on Health
Of the
Committee on Energy and Commerce of the U.S. House of Representatives
July 26, 2018

Chairman Burgess, Ranking Member Green, and distinguished members of the Energy and Commerce Subcommittee on Health, thank you for the opportunity to testify on behalf of AMGA. Founded in 1950, AMGA represents more than 450 multispecialty medical groups and integrated delivery systems that employ more than 175,000 physicians who care for one-in-three Americans. I serve as chair of AMGA's board of directors and throughout my experience with this organization, I have witnessed these medical groups work diligently to provide innovative, high-quality, patient-centered medical care in the most efficient manner possible.

Since 2009, I have served as President and Chief Executive Officer of Prevea Health, a multispecialty group in Green Bay, Wisconsin, that offers over 60 medical specialties, and employs about 350 providers and more than 2,000 employees. I am a board-certified internist and have practiced medicine for over 17 years. In that time, I have witnessed and helped lead major transformations in care delivery throughout Prevea Health.

First of all, I wanted to thank Congress for eliminating the Sustainable Growth Rate (SGR) formula in its attempt to bring more stability to the Medicare Part B program. As you know, the SGR formula necessitated continuous fixes every year, forcing policymakers to think in the short term, and we appreciate that we now have the opportunity and ability to plan for the future. Congress' subsequent passage of the landmark Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 by adjusting payments based on quality and other key factors, represents an opportunity for providers to begin to move away from the current fee-for-service reimbursement model and transition towards value-based care.

MACRA is designed to reward providers by adjusting their Part B payments, which are based largely on the quality of care they provide. In guidance and public comments before it promulgated rules on MACRA, the Centers for Medicare & Medicaid Services (CMS) purported that the law would help achieve three goals for the healthcare system—better care, smarter spending, and healthier people. The law and regulations would achieve this by rewarding physicians who performed well in three key areas: payment incentives, care delivery, and information sharing. Per the MACRA statute, CMS implemented the program by streamlining existing initiatives under the new Merit-based Incentive Payment System

(MIPS) program. Specifically, the program includes the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the Meaningful Use (MU) program. And, for those providers further on the pathway to value-based care, it provides bonus payments for participation in eligible Alternative Payment Models (APMs).

Like many AMGA members, Prevea Health has made significant investments in people and technology in response to MACRA. Prevea Health has been using an electronic health record system for 16 years, so we have thorough access to data on our patient population. But, having data and utilizing it are two different things. We have made investments in platforms that identify gaps in our patients' care and enable us to address them. We also streamlined how our patients interface with us. For example, we offer online appointment scheduling, which has simplified the process for our patients and providers. We continue to make multiple investments in data analytics to improve our patient population's health. Additionally, we are investing in diversifying our provider population. For example, we successfully improved patient and provider satisfaction by hiring multiple registered nurse (RN) care managers. We found that those patients who were managed with a care manager cost a third of what those managed solely by a physician cost. We also have quantifiable evidence that patients with chronic disease who are managed in our patient-centered medical home model have better outcomes and cost the healthcare system less.

These investments were made based on the understanding that MACRA would be implemented with the intent to reward value and innovation. Now, in the third year of rulemaking, it is clear that CMS is not implementing MIPS as intended by this Committee and Congress. If changes are not made, MIPS will not drive change at the clinician level or transition Medicare Part B to value-based reimbursement.

Under the MIPS program, providers have the opportunity to earn an annual adjustment to their Medicare Part B payments based on their performance. These adjustments increase over time. For example, based on performance in 2017, payments would potentially adjust up to 4% in 2019. Performance in 2018 will adjust payments in 2020 up to 5% for top performers. For performance in 2019, top performers could potentially be rewarded a 7% payment adjustment in 2021. Also, in 2019 performance year, a 9% payment adjustment could be rewarded to top performers for 2023. Conversely, as included in the law, poor performance will result in negative payment adjustments of -4%, -5%, -7%, -9% in 2019, 2020, 2021, and 2023 respectively. However, these payment adjustments assume meaningful participation in the program, since Congress designed MIPS to be a budget-neutral program.

We believe that CMS has bypassed the intent of MACRA by excluding 58% of providers from MIPS requirements for performance year 2019 in the recently proposed Quality Payment Program (QPP) or MACRA rule (CMS-1693-P). This exclusion will result in negligible payment adjustments for high-performers that have made meaningful investments to improve quality of care for the communities they serve. This action effectively collapses the MIPS payment adjustment distribution curve. As a result, the payment adjustment for 2021 of up to 7% instead is projected to be 2% for high performers. In fact, CMS has included some form of exclusions to MIPS in all past QPP rules. In 2019, MIPS high performers are expected to receive 1.1%, based on their 2017 performance, even though the law authorized an adjustment up to 4%. In 2020, high performers are expected to receive a 1.5% adjustment, but they were working under the understating that they could potentially earn up to a 5% payment increase.

As you know, MIPS is not a brand-new program, rather a continuation of existing value-based programs, namely PQRS, VM, and MU. CMS did not exclude providers from these programs, as it has from MIPS. Prevea Health utilized its time reporting to these legacy programs to streamline the eventual transition to value. As a result, our efforts to perform in these legacy programs have improved the quality and value of our care. In the four tax identification numbers that Prevea Health bills under partnership with our hospital partners, Hospital Sisters Health System, we scored three perfect scores of 100 and one of 97. However, because of the MIPS exclusions, our payment adjustment does not reward us for this performance.

If Medicare providers are going to successfully transition to value-based arrangements, more of them should be subject to MIPS. I realize that some providers may lack the resources to participate in these programs, but as mentioned above, this transition has been a work in progress for years. In addition, CMS provides technical support and favorable scoring for some providers. Our patient population deserves a provider workforce that is willing and capable of providing the best level of care possible. These MIPS exclusions do not prepare practices of any size to transition to a post fee-for-service payment environment and unfairly penalize those who have worked in good faith to make that transition.

CMS has implemented policies that exclude otherwise eligible clinicians and set a low composite performance score threshold, which determines the physician payment adjustments under MIPS. The resulting payment adjustments for high performers in the program will neither incentivize the required investments in health information technology and process changes, nor will they cover the costs and burdens associated with reporting the required data. Finally, they will not incentivize healthcare provider organizations to engage with CMS in moving toward value-based care.

We commend this Committee on its commitment to MACRA implementation oversight and stand ready to assist you in this process. Thank you for the opportunity to testify.

Mr. BURGESS. Thank you, Doctor.
 Dr. Parekh, you are recognized for 5 minutes, please.

STATEMENT OF DR. PARAG PAREKH

Dr. PAREKH. Chairman Burgess, Ranking Member Green, and members of the Health Subcommittee, thank you for the opportunity to provide feedback on MACRA implementation.

I am here today on behalf of the Alliance of Specialty Medicine, a coalition of 15 medical specialty societies, representing more than 100,000 physicians and surgeons. My name is Dr. Parag Parekh. I am a private-practicing eye surgeon in rural western Pennsylvania and the only board-certified, fellowship-trained ophthalmologist specializing in cataract and refractive surgery as well as cornea and glaucoma surgery in that entire geographic area. I chair the Government Relations Committee of the American Society of Cataract and Refractive Surgery, one of the alliance member organizations.

The alliance greatly appreciates your leadership to repeal the SGR, create MACRA, and revamp the legacy quality reporting programs. Listening to physicians' concerns, Congress created MIPS, which streamlined the existing programs and allows physicians to focus on the measures and activities that most closely align with our practices. Successful implementation and long-term viability is important, since MIPS is the only pay-for-performance option for many specialists. We also appreciate the technical corrections advanced earlier this year, which strengthen the law, continue progress made to date, and will improve the ability of specialty physicians to engage in quality improvement activities.

MACRA provides two value-based reimbursement tracks for physicians under Medicare. Under one, physicians can opt to remain in fee-for-service and participate in MIPS. In the other, physicians can participate in advanced alternative payment models. For many specialists, including ophthalmologists like me, MIPS is the only meaningful and viable pathway. Many specialists have no opportunities to participate in advanced APMs, given that they are designed with a primary care focus.

While there is always more work to be done, many specialists have made significant strides to deliver high-quality and efficient care. In the last 50 years, ophthalmologists have made tremendous strides in cataract surgery by reducing complications and the variations in cost. Ophthalmology has developed meaningful outcomes measures, including for cataract surgery, which are being reported through the MIPS program. And CMS proposed to include cataract episode cost measures as well. Therefore, it is critically important that Congress maintain a viable fee-for-service option in Medicare Part B, along with the MIPS program, to ensure that specialists can continue to meaningfully engage in the quality improvement initiatives and deliver high-quality care.

The MIPS technical corrections gives CMS additional flexibility to determine the appropriate weight of the MIPS cost category, allow CMS to gradually increase the performance threshold before reaching the mean or median standard, and exclude Medicare Part B drugs from MIPS payment adjustments and eligibility determination.

However, additional modifications are needed to support more meaningful measures and lessen the complexity of reporting and scoring. Currently, clinicians must comply with four performance categories, each with distinct requirements and scoring methodologies. Allowing clinicians to get credit across multiple MIPS categories by engaging in a single set of actions would make the program much less confusing.

For example, tracking outcomes through a clinical data registry and using such data to improve patient care should count for multiple categories of MIPS. Alliance specialty societies continue to invest heavily in the development of quality measures, including outcome measures and those reported by patients, and have established robust clinical data registries that have been qualified for use in the MIPS program. In my own specialty, the American Academy of Ophthalmology has the IRIS registry, which serves as a key tool in reporting MIPS data and tracking outcomes.

Measure implementation is another ongoing challenge. Our member societies continue to develop new specialty-focused measures, but CMS threatens to eliminate them when they do not immediately produce enough data to set reliable performance benchmarks. In addition, for more established measures previously developed by specialties, CMS has determined some of them to be topped-out and, then, remove them from the program, even though these measures continue to improve care and continue to be meaningful to specialty physicians. Removing them from the program limits our ability to participate in MIPS.

Finally, the alliance opposes MedPAC's recommendation to eliminate the MIPS program and replace it with the voluntary value program, which relies on population-based measures geared towards primary care and eliminates the one program, MIPS, that specialists can actually use to demonstrate and improve their quality and overall value. The VBP would discourage specialists from developing relevant quality and outcomes measures, disincentivize the use of high-value clinical data registries to track patterns of care, and thwart efforts to collect and report performance data.

Again, thank you for your work to ensure successful and timely implementation of MIPS.

[The prepared statement of Dr. Parekh follows:]

**Summary of Testimony from the Alliance of Specialty Medicine by Parag D. Parekh, MD, MPA
American Society of Cataract & Refractive Surgery (ASCRS)
Before the House Energy and Commerce Health Subcommittee
“MACRA and MIPS: An Update on the Merit-based Incentive Payment System”
Thursday, July 26, 2018**

Moving to Value-Based Payment in Medicare: For many specialists, the Merit-based Incentive Payment System (MIPS) is the only meaningful and viable pathway for participating in programs established under MACRA. In fact, many specialists have no opportunities to participate in Advanced Alternative Payment Models (APMs) since the vast majority were designed with a focus on primary and preventive care. Only a handful of Advanced APMs have been designed for a narrow subset of specialty physicians and complex health conditions they are best equipped to diagnose, treat and lead teams in managing patient care. Specialty physicians have faced significant challenges as they have attempted engagement in Medicare ACOs. The Alliance has recommended a number of changes in Medicare’s Shared Savings Program regulations that would address these and other challenges with ACO participation by specialists. For specialty physicians, however, engagement in the MIPS track, which relies on a fee-for-service reimbursement structure, remains the most appropriate mechanism.

Importance of Technical Corrections Approved by the Congress: We appreciate the provisions in the Bipartisan Budget Act of 2018 to ease the ramp up of the MIPS Program and to allow those committed to value-based care improvement to remain in this QPP track, especially the provision giving CMS three additional years of flexibility to determine the appropriate weight of the MIPS cost category based on the availability of relevant measures. A significant amount of work remains to ensure that new episode-based cost measures are developed and integrated to accurately reflect the complexities of cost measurement, without inadvertently discouraging clinicians from caring for high-risk and medically complex patients. The Alliance also appreciates provisions that allow CMS to more gradually increase the MIPS performance threshold year-over-year before reaching the “mean or median” standard and the technical correction that ensures Medicare Part B drugs and other items and services outside the physician fee schedule are not included in the application of MIPS payment adjustments and determination of MIPS eligibility.

Additional Refinements to MIPS Still Needed: The Alliance supports practical solutions that would lessen the complexity of MIPS scoring, including additional opportunities for clinicians to get credit across multiple MIPS categories for engaging in a single set of actions. Measures and reporting mechanisms that recognize patient and clinician diversity must be supported. Despite the advantages physicians gain through their use, qualified clinical data registries (QCDRs) face ongoing challenges connecting to certified electronic health record technology (CEHRT), which is prevented by vendors blocking the bi-directional exchange of this important health information. This is a huge impediment to our success and we strongly encourage you to address this obstacle. Measure implementation is another ongoing challenge and more flexibility is needed, especially for smaller specialties, to support participation in MIPS and to incentivize the data collection needed for benchmarks over time.

MedPAC Recommendation: The Alliance opposes the Medicare Payment Advisory Commission’s (MedPAC) recommendation to eliminate the MIPS program and replace it with a new Voluntary Value Program (VVP). The Alliance has shared its concerns with the Commission and has called to their attention the lack of Advanced APMs in which specialists can meaningfully engage, the limitations of population-based measures in determining quality and cost of specialty medical care, and MACRA’s intent to promote the development of clinically relevant, specialty-based quality measures. We urge the committee to disregard MedPAC’s recommendation and instead work toward ongoing improvements to the MIPS program as it continues to mature.

Testimony from the Alliance of Specialty Medicine by Parag D. Parekh, MD, MPA

American Society of Cataract & Refractive Surgery (ASCRS)

Before the House Energy and Commerce Committee

Subcommittee on Health

“MACRA and MIPS: An Update on the Merit-based Incentive Payment System”

Thursday, July 26, 2018

Chairman Burgess, Ranking Member Green, and members of the Health Subcommittee, thank you for the opportunity to provide feedback on implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). My name is Dr. Parag Parekh. I am a private practicing ophthalmologist in rural Western Pennsylvania, and the only board-certified, fellowship-trained ophthalmologist specializing in cataract and refractive surgery, as well as cornea and glaucoma surgery, in that geographic area and the entire 5th district. I am an active member in multiple professional medical societies. Notably, I am the Chair of the American Society of Cataract & Refractive Surgery (ASCRS) Government Relations Committee where I have served as a member for the past 10 years. I also serve on relevant technical expert panels (TEP) formed by the Centers for Medicare and Medicaid Services (CMS) to address the programs established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and implemented under CMS’ Quality Payment Program (QPP).

I am here today on behalf of the Alliance of Specialty Medicine (“Alliance”). 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. As patient and physician advocates, the Alliance welcomes the opportunity to provide input in the formulation of health and Medicare policy.

Today's hearing is an important step to ensuring the Congressional intent of MACRA in providing flexible options for clinicians to meaningfully engage in the program. The Alliance has worked closely with policymakers and CMS to ensure that implementation of the law is consistent with Congress' intent. For this reason, we greatly appreciate that Congress included "technical corrections," as part of the February 9, 2018 Continuing Resolution (CR). Not only will these adjustments strengthen the law and continue progress made to date, it will significantly improve the ability of physicians, particularly specialists, to engage in quality improvement activities, and specifically in the Merit-based Incentive Payment System (MIPS) track of MACRA.

Specialists are an essential and needed component of the healthcare system. Specialists use their deep knowledge and expertise to reach a precise medical diagnosis, present the full array of available interventions, collaborate closely with their patients to determine which option is most appropriate based on their preferences and values, and coordinate and manage their specialty and related care until treatment is complete. No other clinician, provider or health care professional can replace the value offered by specialty physicians. To that end, MIPS must be implemented successfully and set up for long-term viability since it will be the only option for many of these specialists to engage in pay-for-performance given they will have no other option than to remain in fee-for-service.

Moving to Value-Based Payment in Medicare

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. For example, the American Association of Neurological Surgeons (AANS) and Congress of Neurological Surgeons (CNS) support multiple registries that promote national quality research efforts, including comparative effectiveness research, practice data collection requirements for board certification, and robust data for structured quality improvement studies in the areas of spine surgery, cerebrovascular, stereotactic radiosurgery and brain tumors. In addition, AANS/CNS is working on other clinical decision support tools, including predictive risk calculators to counsel patients and assess their risks and potential outcomes from spine surgery. Another example is the American Gastroenterological Association's (AGA) "My IBD Manager" patient app and the "Ask AGA: IBD" clinical platform. These tools work together to improve the physician/patient relationship and to simplify access to clinical evidence and clinical guidelines, while providing patients a one-stop-shop to learn about their disease, monitor symptoms and share information with their health care team.

Members of this committee will recall Congress' 17 interventions over 11 years, which were necessary to prevent steep reductions in Medicare physician payment under the Sustainable Growth Rate (SGR) formula – in some cases up to 24%. Without your help, physician practices would have been financially devastated and access to care would have been severely restricted for America's frailest, and most vulnerable population. Congress also established quality improvement programs on top of the flawed SGR reimbursement mechanism, including the Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier (VM) and the Medicare and Medicaid Electronic Health Record Incentive Program, or "Meaningful Use." While the goals of these programs were laudable, they had disparate reporting requirements that included overlapping measures. Physicians and practices were at

a loss to keep up with the various deadlines and would face stiff penalties if they made even minor clerical errors due to the “all-or-nothing” nature of the programs. Congress listened to the concerns about these legacy quality reporting programs raised by physicians and created the MIPS program, which streamlined the existing programs and allowed physicians to focus on the measures and activities that most closely align with their practices. As a key example of that, the addition of the clinical practice improvement activities gives physicians MIPS credit for activities designed to improve care—many of which physicians were already doing.

Now, with the looming threat of yearly cuts in Medicare reimbursement due to the flawed SGR removed, thanks to Congress, and members of this committee in particular, Alliance member organizations can further efforts to improve specialty care with incentives and technical assistance provided under MACRA.

Importantly, the Alliance appreciates the approach Congress took, and in particular, this committee, when drafting MACRA, which established two value-based reimbursement tracks for physicians under Medicare. Under one track, physicians can opt to remain in fee-for-service and participate in MIPS. Through the MIPS program, physicians report and are measured on their performance on: (1) relevant, self-selected quality measures, typically developed by and for their specialty; (2) meaningfully use certified electronic health technology (CEHRT), reporting their performance on objectives and measures that generally align with how their practice uses EHRs and other health information technologies; (3) demonstrating clinical practice improvement through various activities, such as using data from a qualified clinical data registry to tailor care management plans for discrete patient populations within their practice or collect and follow-up on patient experience and satisfaction data related to beneficiary engagement; and finally, (4) cost of care provided to certain beneficiaries in

key clinical areas, although considerable work remains before physicians, and specialists in particular, should be held accountable for efficient resource use. Specifically, CMS should continue efforts to develop episode-based cost measures and remove flawed population health measures that potentially hold physicians accountable for the cost of care they did not provide. In the second track, physicians can significantly participate in Advanced Alternative Payment Models (APMs) and potentially earn incentives and increased reimbursement under Medicare. Both tracks are built on Medicare's current fee-for-service payment system, and both entail financial risk and reward. Both tracks also measure quality of care, and to a certain extent, hold participants accountable for financial efficiencies.

For many specialists, including ophthalmologists like me, MIPS is the only meaningful and viable pathway for participating in programs established under MACRA. In fact, many specialists have no opportunities to participate in Advanced APMs, at all. A review of CMS' MIPS exclusion tables from the 2017 Quality Payment Program Final Rule shows that family medicine, internal medicine, obstetrics/gynecology, and nurse practitioners, are the primary specialties that will make up the vast majority of Advanced APM qualifying participants (QPs), based on 2017 estimates. By comparison, CMS projected that specialists, such as ophthalmologists, neurosurgeons and rheumatologists, would be less likely to engage in APMs, with only 153 (0.7 percent), 46 (0.8 percent) and 79 (1.4 percent) of these specialty physicians, respectively, expected to reach QP status based on 2017 performance.

As this committee is aware, only a handful of Advanced APMs have been designed for a narrow subset of specialty physicians and complex health conditions they are best equipped to diagnose, treat and lead teams in managing patient care. The vast majority of Advanced APMs, including the various Medicare Accountable Care Organizations (ACOs) and the Medical Home Model, were designed with a focus on delivering primary and preventive care and to address broad population health goals, led by

teams of primary care providers. Specialty physicians have attempted engagement in Medicare ACOs but have faced significant challenges. For example, small, primary-care led ACOs maintain closed or “narrow networks,” excluding some or all specialty physicians. While specialists have had more success participating in large, hospital- or health system-centered ACOs, their engagement has been passive. In fact, specialists that participate in large ACOs tell us they have no meaningful role in improving the quality or cost of care for the ACO’s assigned population because there are no metrics focused on the conditions they cover or the care they deliver. The Alliance has recommended a number of changes in Medicare’s Shared Savings Program regulations that would address these and other challenges with ACO participation by specialists, and we will continue those efforts.

Even before passage of MACRA, several Alliance organizations were working diligently to foster alternative payment and delivery models for their specialty through existing agency channels. Despite a multitude of meetings with CMS’ Innovation Center, these models were dismissed – even those that addressed services representing a high proportion of Medicare expenditures and had been successfully tested in the private insurance market. Candidly, Innovation Center officials told some of our organizations that models centered on primary care were the agency’s priority. Now, as evidenced by the multiple letters of intent and proposed models submitted for review and deliberation by the Physician Focused Payment Model Technical Advisory Committee (PTAC), it should be clear that specialists are eager to contribute to responsible stewardship of federal health programs. It is frustrating to be viewed as a costly part of the Medicare program, while simultaneously being turned away when we present proactive, innovative solutions and proposals.

While there is more work to be done to encourage value-driven health care, and several disease states and procedures are prime for quality and resource use improvements, many specialists have made

significant strides to engage in activities that deliver high-quality, efficient care. In fact, some have already refined key conditions and procedures through medical advancement and technological innovation. For example, some specialists have moved services and procedures from expensive inpatient settings to lower-cost outpatient settings; some perform all aspects of a surgical service in the physician office-setting, ensuring high-quality and reducing inefficiencies, while lowering government and beneficiary costs; and, others have eliminated variations in cost, quality and access to their procedures through long-term performance improvement, which is documented in the literature.

A key example is my own specialty of cataract surgery. Cataract surgery is performed in either an Ambulatory Surgery Center (ASC) or Hospital Outpatient Department (HOPD). When complications, but also variations in outcome occur, it is often due to patient co-morbidities, such as diabetes, glaucoma, macular degeneration or retinal disorders, or other significant pre-existing health issues. There have not been demonstrated gaps in the quality, cost, or access to care based on the site of service. In the last 50 years, since the advent of phacoemulsification, ophthalmologists have made tremendous strides in improving cataract surgery so that complications are relatively rare. While still an intensive procedure requiring the special skill of ophthalmologists, the medical innovation of the last half-century means that patients will have a reliable assurance that the outcome of their surgery will contribute positively to their overall quality of life. There are very few opportunities for further improvements to quality or efficiency in cataract surgery, which makes developing or participating in an Advanced APM difficult.

For me and certain other specialists, engagement in the MIPS track, which relies on a fee-for-service reimbursement structure, remains the most appropriate mechanism. More specifically, the MIPS track allows specialists – those without suitable Advanced APMs options – a fair opportunity to remain in fee-for-service while continuing to measure, report, and improve performance on key areas of clinical

quality that matter to their practice and their patients. It is critically important that Congress maintain a viable fee-for-service option in Medicare Part B, along with the MIPS program, to ensure specialists can continue to meaningfully engage in federal quality improvement initiatives, and more importantly, continue to deliver high-quality care to America's senior and disabled population.

Importance of Technical Corrections Approved by the Congress

We greatly appreciate that Congress included provisions in the Bipartisan Budget Act of 2018 (Public Law No. 115-123), to ease the ramp up of the MIPS Program and to allow those committed to value-based care improvement to remain in this track of the QPP. We are particularly supportive of the provision that would give CMS three additional years of flexibility to determine the appropriate weight of the MIPS cost category based on the availability of relevant measures. Given the state of readiness of cost measures, this flexibility is essential. A significant amount of work remains to be done to ensure that new episode-based cost measures are developed and integrated in a way that accurately reflects the complexities of cost measurement and does not inadvertently discourage clinicians from caring for high-risk and medically complex patients.

I have been participating in efforts to develop episode-based cost measures. I served on two CMS-appointed technical expert panels related to these measures, including the ophthalmic clinical committee that developed the cataract surgery measure. Throughout this process, my fellow committee members and I have worked to ensure that physicians are not penalized for the cost of care outside their control, unlike the current flawed measures held over from the Value-based Payment Modifier—Medicare Spending per Beneficiary and Total per Capita Cost of Care that are meaningless to specialists. We have looked at every aspect of care related to cataract surgery, including pre-, intra-, and post-operative costs. We accounted for difference in cost related to the differing facility payments for procedures performed

in ASCs versus HOPDs, and risk -adjusted for costs related to significant ocular co-morbidities. My colleagues serving on other subcommittees also grappled with cost drivers relevant to their own conditions and procedures. It is a painstaking process that requires analysis tailored to each unique procedure or condition.

While CMS is proposing to include the cataract surgery episode measure and seven other procedure and condition-based episodes in MIPS for 2019, it will be several years before a significant number of measures can be developed. The additional time provided by the technical corrections will allow further refinement and development of these measures.

In addition, we appreciate provisions that allow CMS to more gradually increase the MIPS performance threshold year-over-year before reaching the “mean or median” standard. For 2019, CMS has proposed to increase the performance threshold to 30 points, up from the 2018 performance threshold, which was set at 15 points, and the 2017 performance threshold, which was set at 3 points. Gradually increasing the performance threshold gives physicians the opportunity to implement necessary practice changes as they gain experience. It also ensures that the performance threshold is not set too high, which could discourage participation or negatively impact practices with fewer resources. Data on physician participation and performance collected by CMS will best determine clinician readiness and should guide the agency as it works with the physician community on increasing program requirements. CMS reports that 91% of eligible physicians participated in the first year of MIPS, which should provide ample data for the agency to evaluate and determine how to proceed in coming years.

We also appreciate the technical correction that ensures Medicare Part B drugs and other items and services outside the physician fee schedule are not included in the application of MIPS payment

adjustments and determination of MIPS eligibility. Without the correction, CMS would have been authorized to penalize and reward clinicians based on the volume of medicines they administer in their offices. Not only would these adjustments potentially hinder access to care for beneficiaries whose physicians are penalized, but positive adjustments to practices that administer Part B drugs would unfairly reduce the incentive pool for all other clinicians.

Alliance member organizations, such as my own, ASCRS, have developed extensive training materials to help physicians understand and thrive in the program. Efforts include the development of guides tailored to each specialty, in-person training programs for physicians and their practice administrators, webinars and other online education, infographics and visual aids, among other resources. These extensive education efforts have already started to pay off as many specialists are participating in MIPS and are active members of the quality improvement community. Additional time and flexibility will ensure that all specialists are prepared and can be successful as the performance thresholds increase each year.

Additional Refinements to MIPS Still Needed

While the Alliance greatly appreciates the added flexibilities included in the Bipartisan Budget Act of 2018, we believe that additional modifications are needed to make MIPS less administratively burdensome and costly for physicians; more meaningful, relevant and actionable to both physicians and patients; and more transparent. A more simplistic and applicable approach will ensure not just greater clinician engagement, but more purposeful engagement, which is the only way to effect real change. The Alliance supports practical solutions that would lessen the complexity of MIPS scoring, including additional opportunities for clinicians to get credit across multiple MIPS categories for engaging in a single set of

actions. Members of the Alliance have been working with its colleagues to flesh out these proposals and would be happy to have a more detailed follow-up discussion with members of the subcommittee.

To that end, we greatly appreciate proposals put forward by CMS in its recent Year 3 Quality Payment Program proposed rule that would address key challenges physicians have faced with the MIPS program, and particularly the Promoting Interoperability performance category, formerly known as the Advancing Care Information performance category. CMS is proposing to reduce the number of objectives and measures that physicians would report to be meaningful users of certified electronic health record technology, eliminate the convoluted scoring construct, and to focus exclusively on a clinician's performance on a more limited set of measures. If finalized, these modifications will make a meaningful difference in the ability of many specialists to engage in the MIPS promoting interoperability performance category. We look forward to working with CMS, Congress, and members of this committee on additional refinements that will further interoperability across electronic health records and other health information technologies, including qualified clinical data registries (QCDRs). I'll discuss more about this in a moment.

There is also an ongoing need to support measures and reporting mechanisms that recognize patient and clinician diversity. Most specialties still lack a robust set of meaningful measures due to the complexity of their care, nuanced variations in their patient population, and ongoing barriers to data collection. Nevertheless, members of the Alliance continue to invest in efforts to better track the performance of their care. Specialty societies in the Alliance continue to invest heavily in the development of quality measures, including outcomes and those reported by patients, and have established robust clinical data registries, that have been qualified for use in the MIPS program. These QCDRs are especially important for specialty physicians looking to deepen their understanding of quality and performance for

relevant episodes of care. Not only do the data collected and resultant information fuel important improvements in practice-level outcomes, it also helps specialty societies engage in education at the national level, benefiting their respective professions at the broadest level. In my own specialty of ophthalmology, the IRIS registry serves as a key tool in not only reporting MIPS data, but tracking outcomes for ophthalmic surgery and the care of patients with chronic eye disease. Despite the advantages physicians gain through their use, QCDRs face ongoing challenges connecting to certified electronic health record technology (CEHRT), which is prevented by vendors blocking the bidirectional exchange of this important health information. The Alliance hopes to work with this Committee to ensure this challenge is addressed by the Secretary as required under the 21st Century Cures Act. This is a huge impediment to our success and we strongly encourage you to address this obstacle.

Measure implementation is another ongoing challenge. Specialty societies often find themselves in a catch-22 in that newly implemented measures need to be reported by a sufficient number of physicians to produce reliable benchmarks that can be used for performance scoring. Our member societies continue to confront situations where they invest heavily in the development of new, specialty-focused measures, but when they do not immediately produce enough data to set reliable performance benchmarks, CMS threatens to remove them from the program. The Alliance asks for more flexibility, especially for smaller specialties, to support physician participation in MIPS and to incentivize the collection of data needed for benchmarks over time. We appreciate that CMS has proposed an “opt-in policy” that would allow previously exempted physicians to participate in the program. This policy, if finalized, will significantly assist with data collection and the establishment of benchmarks that are desperately needed for new specialty-focused quality measures. Additional incentives, such as assigning “high priority” status to new quality measures, would also help support the reporting of new measures.

MedPAC Recommendation

The Alliance would also like to express our concerns with the Medicare Payment Advisory Commission's (MedPAC) recommendation to eliminate the MIPS program and replace it with a new Voluntary Value Program (VVP). MedPAC's recommendation, coupled with forthcoming recommendations to "rebalance" the Medicare physician fee schedule (MPFS) toward primary care, undercuts and devalues the role of specialists in providing thorough examinations, rendering accurate diagnoses, offering a complete range of treatment options, to include performing surgery, and delivering comprehensive and effective management of complex health conditions.

MedPAC has specifically called for the *Congress to eliminate the current Merit-based Incentive Payment System and establish a new voluntary value program in fee-for-service Medicare in which clinicians can elect to be measured as part of a voluntary group and qualify for a value payment based on their group's performance on a set of population-based measures*. According to MedPAC staff, spending implications include distributing the \$500 million MIPS exceptional performance bonus pool to improve payment for primary care or encourage engagement in Advanced APMs.

We again reiterate that the MIPS program provides the only mechanism for many specialists and subspecialists to engage in federally-sponsored quality improvement activities and demonstrate their commitment to delivering high-value care. Specialty care is often targeted as being high cost and of variable quality. These claims cannot be validated nor addressed by adding yet another program that relies on a set of population-based measures more geared toward primary care and eliminating the one program that specialists can actually use to demonstrate and improve their quality and overall value. Eliminating MIPS in favor of MedPAC's proposed new quality program would discourage specialty physicians from developing robust quality and outcomes measures that are most relevant to their patient

populations, disincentivize the use of high-value clinical data registries to track patterns of care, and thwart efforts to collect and report performance data, overall.

It would also exacerbate the whiplash and confusion that physicians are already experiencing as they transition from multiple pay-for-reporting and pay-for performance programs that have evolved since the Physician Voluntary Reporting Program (PVRP) commenced in 2006. The types of changes we are all hoping for take time—time for policymakers and regulators to work with stakeholders to develop and establish the policies, and time for physicians to implement the programs and adapt their practices to the changes. It took 15 years to solve the SGR conundrum and develop MACRA; scrapping the MIPS program as a failure when it has barely launched is grossly inappropriate and unfair, particularly given the support the medical community demonstrated in helping the Congress and this committee establish the program under MACRA.

We disagree with MedPAC that the reporting requirements under MIPS are ineffective at improving care because physicians can choose the quality measures to be graded on. In contrast, this is one of the most important aspects of the MIPS program, which was recognized by the drafters of the MACRA law. Had Congress intended for the Medicare agency to select quality measures for physicians to report, it wouldn't have emphasized the development of quality measures by medical specialty societies and provided requisite funding. Physicians know which measures are most applicable to their practice based on their clinical specialty or subspecialty area, the services and treatment options they provide, and the patient population they serve. Holding physicians, and particularly specialists, accountable for measures that are not applicable to their practice or patients would pose an undue regulatory burden and result in meaningless data of little value to both specialists trying to improve the quality of care and patients trying to make well-informed medical decisions about the quality of care provided by specialists.

While we understand CMS' interest in pursuing a more parsimonious set of measures through initiatives such as "Meaningful Measures" and "Patients Over Paperwork," it is critical that CMS maintain a diverse enough set of measures to appropriately capture the quality of care provided across specialties and practice settings.

We also disagree with MedPAC that quality measures do not focus on clinical outcomes. Out of the 271 MIPS quality measures, more than 168 are 'high priority' measures, which include more than 70 outcomes measures. This does not include outcomes measures that are exclusive to the multiple specialty-focused QCDRs. In ophthalmology, including cataract surgery, the vast majority of clinical quality measures are outcomes-based. Specialty societies continue to develop outcomes-based clinical quality measures where appropriate and feasible.

The Alliance has shared its concerns with MedPAC about the adverse impact the Commission's recommendation would have on specialty physicians and the beneficiaries they serve. Specifically, we called to their attention the lack of Advanced APMs in which specialists can meaningfully engage, the limitations of population-based measures in determining quality and cost of specialty medical care, and MACRA's intent to promote the development of clinically relevant, specialty-based quality measures. Moreover, we explained that fee-for-service remains the only viable reimbursement structure for many specialists and subspecialists.

Similar to the discussion above regarding the VM cost measures, population-based quality measures, such as those used in Medicare's ACO program or reported by Medicare Advantage Organizations (MAOs) under the "Star Ratings" program, are not reflective of specialty medical care. As such, these measures cannot help specialists improve or change behavior, and will not help CMS differentiate between high and low-value specialists, nor yield meaningful information that drives

beneficiaries toward high-value specialty providers. In fact, one of the concerns specialty physicians have raised with CMS is that the quality measures in the Medicare ACO program and Medicare Advantage hinder specialty participation because their value cannot be demonstrated. Both Medicare ACOs and Medicare Advantage plans have “narrow networks” that exclude specialist participation because few of the quality measures they are held to account for specialty medical care. Rather, these models are focused on broad population-health measures that are generally under the purview of primary care providers. This is one reason why small, physician-led ACOs, are dominated by primary care physicians, and why larger, hospital- or health system-led ACOs only passively engage specialists.

We urge the Congress, and members of this committee, to disregard MedPAC’s recommendation and instead work toward ongoing improvements to the MIPS program as it continues to mature.

The Alliance of Specialty Medicine is committed to the successful and timely implementation of the law while still providing practitioners time and opportunities to succeed. We look forward to working with the subcommittee to ensure the implementation of MACRA continues to be successful, and we would be happy to discuss any other questions you may have going forward.

Mr. BURGESS. Thank you, Doctor.

And, Dr. Ransohoff, you are recognized for 5 minutes, please.

STATEMENT OF DR. KURT RANSOHOFF

Dr. RANSOHOFF. Thank you, Chairman Burgess, Ranking Member Green, and esteemed members of the committee, for inviting me to present today.

For the last few years, my group, Sansum Clinic in Santa Barbara, California, has been on a journey going from the SGR payment system to become a devoted MIPS provider, only to evolve into a Track 1+ ACO. Our journey will provide some insight into what is good and what is less good about the recent shifting of the tectonic plates on which the Medicare physician payment system stands.

Before going further, let me tell you about me and my group. I am a general internist. I have practiced in the same exam rooms for the last 26 years. I have been doing this long enough to recall handwriting my patient progress notes and to have cared for multiple generations of families. I have been able to say to a 70-year-old man, "Your murmur sounds exactly like your dad's did at your age." I have been honored to have practiced for that long in the same setting.

Sansum Clinic is a nearly 100-year-old not-for-profit medical foundation with 200 doctors. It is an oddity in that it is not affiliated with a hospital. We have participated in the whole alphabet soup of modern health insurance from HMOs to PPOs to ACOs.

For the last 2 years, I have been the Board Chair of America's Physician Groups. APG is a professional association representing more than 300 of the nation's most advanced medical groups in the country, many of whom take full financial risk in caring for their patients.

With that background, let me return to our story of our journey from the SGR days to being a Track 1+ ACO. Whatever criticisms there are about MIPS and MACRA, almost all doctors will say thank you, as all of us have, to Congress for doing away with that flawed process. In the SGR days, our budgeting process was basically chaos. The cut that was generated by the formula would mean that we would be entirely unable to balance our books. So, we just ignored it and prayed that the implementation would be put off, as it was every year, usually at the 11th hour. We also had a great sigh of relief when the SGR was repealed.

Then, there was this new process, MACRA, on the scene. Over the last few years, our clinic became a very successful MIPS participant. We got 100 and we made lot of investments in care processes to enhance the health of our populations and patients. And yet, we have left MIPS and we have gone on to become a Track 1+ ACO. The details in the journey are included in my remarks, but I will try to summarize the take-home messages of our journey.

What have we learned? SGR was really problematic, and though there remains some issues within the MIPS program that need to be addressed, it is far and away a better system than the dreaded "doc fix" gamble that we all had to rely on for years. The way MIPS has been implemented is not the way it was planned. It is an asymmetric process. The intended larger reward for high scorers is

gone, but the intended large loss for those who score poorly is still there. Most of that is because so many doctors are excluded from MIPS, more than half a million, according to The Federal Register.

We fully recognize that exemptions are necessary in some cases, but this level of exemptions undermines the spirit of the law and impedes the goal of moving our nation's healthcare system to value. There are real benefits to the patients and to the healthcare system that come from the clinical processes that are put in place to try to do this work well. At the same time, the metrics on which doctors are graded need to be relevant for their specialty and their practice.

Here are a few suggestions that we think can encourage the movement from volume to value:

Lower the threshold for excluding groups entirely from MIPS and, thereby, increase the number of physicians participating in the program. At the same time, in recognition of the fact that smaller groups have fewer resources, MIPS for smaller groups may need to look different than MIPS for larger groups. In other words, give smaller groups a different test more suitable for their resources, instead of excluding them entirely.

Even if there are flaws in MIPS, there is value for individual patients and populations and, importantly, the payer of all of this, the American taxpayer, in encouraging data collection and encouraging the use of, and the reporting of, high-quality and high-value care. The processes that are created to do that will help move Medicare from volume to value. We should find ways of making it feasible for more providers to participate in that process, instead of excluding them. MIPS can and should be fixed. It should not be discarded.

Thank you for allowing me to speak, and I will be happy to answer any questions.

[The prepared statement of Dr. Ransohoff follows:]

**Statement of
Kurt N. Ransohoff, MD, FACP
Chief Executive Officer
Sansum Clinic, Santa Barbara, CA
Before the House Energy and Commerce Committee,
Subcommittee on Health**

July 26, 2018

Thank you, Chairman Burgess, Ranking Member Green, and esteemed members of the Committee for inviting me to present today.

My group, Sansum Clinic, has been on a journey, going from the previous sustainable growth rate (SGR) payment system, to becoming a devoted MIPS provider under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), to becoming a Track One Plus Accountable Care Organization (ACO), all over a period of several years. Our journey will provide some insight into what is good and what is less good about the recent shifting of the tectonic plates on which the Medicare physician payment system stands.

Before going further, let me tell you about me and my group. I am a general internist. I went to UCLA Medical School and then did my internship, residency, and chief residency at UCLA. I was on the faculty there for a few years after finishing my training, before moving to Sansum Clinic in Santa Barbara as a general internist 26 years ago. I've continued to practice in the same exam rooms for the last 26 years. I've been doing this long enough to recall hand-writing my patient progress notes and to have cared for multiple generations of family members. I have been able to say to a 70-year-old man – "Your heart murmur sounds just like your dad's at your age." I've been honored to practice for that long of a time in the same setting.

Sansum Clinic is a nearly 100-year-old not-for-profit Medical Foundation. It is an oddity in that it is not affiliated with a hospital. We have about 200 doctors and care for about 125,000 patients each year. We have almost all of the different specialties. Over the last 40 years, we have been involved in capitated HMOs, Fee For Service (FFS) models, POS plans, PPOs, ACOs, and the whole alphabet soup of modern health insurance. That is important because we have been comfortable with the many different models and can appreciate the advantages and disadvantages of each.

For the last two years, I have been the Board Chair of America's Physician Groups (APG). APG is a professional association representing more than 300 of the most advanced medical groups in the country. All are involved in integrated and coordinated care, with most taking risk to various degrees. Our tag line "Taking Responsibility for America's Health" is truly what our groups do. We all take clinical responsibility for America's health. Many take complete financial responsibility too.

With that background, I will return to the story of our journey from the SGR days to being a Track One Plus ACO.

Whatever criticisms there are about MIPS and MACRA, almost all doctors will say "Thank You!" to Congress for doing away with the flawed SGR process. In the SGR days, our budgeting process would begin with trying to manage the double-digit decrease called for by the SGR formula. It would make it impossible to balance our budget. The implementation of the cut would mean insolvency, so we would explain to our Board that we were going to ignore the projection and assume a flat payment from Medicare or a one percent increase. Board members would understandably think it was crazy to do this the first time they heard about this

process. Then they would get used to the annual chaos of ignoring what was published. We all sighed a great sigh of relief when the SGR was repealed.

There was then this new process, MACRA, on the scene. It was a bit of a mystery at first. There was a wonderful slide APG had created that showed a doctor standing at a fork in the road, with one fork indicating the MIPS road and the other Advanced Alternative Payment Model (AAPM) road. That was how we all saw it. Everyone had to choose, either you go down the MIPS road or the AAPM road. There was no rest area in the slide. There was no parking lot in which someone could just wait until a different road was built, or just settle in the parking lot and never move on.

That is important. At the outset, the idea was that almost everyone would be in MIPS or an AAPM. The idea was to move everyone from volume to value. As a provider you had to choose one of the roads. So, we chose to be a MIPS provider. I was a zealous supporter of MIPS. I participated in panels explaining why MIPS was a good choice for many groups, including ours. And yet, as I said, we ultimately wound up being a Track One Plus ACO. What happened?

We believed MIPS would be as presented. Most would participate. Those who moved strongly in the value direction would be rewarded as outlined, with at least a four percent bonus for high-scoring groups in the initial 2017 performance year. The bonus would increase in later years. There would be a large pool of money that would fund high-scoring groups, with the funding provided by groups that did not move in the value direction.

Due to multiple factors in the implementation process, that is not how it played out. Many were exempted. The initial year became a transition year, with the ability to meet a neutral adjustment with minimal effort. Then there were lots of exclusions. There were rural

exclusions, small group exclusions, exclusions related to hurricanes and weather events (whether or not the physician was indeed affected by said event). The most powerful exclusion was based on the low volume threshold, under which one was exempt from MIPS. It went from \$30,000 and 100 patients, which, according to the Federal Register, would have exempted 380,000 providers to \$90,000 or 200 patients, exempting more than 540,000 providers. We fully recognize exemptions are necessary in some cases, but this level of exemptions undermines the spirit of the law.

We had assumed it was going to be a standardized test, like the SAT, which most everyone would take and would be graded on the curve. Instead, it became an SAT test, still graded on the curve, but with only Advanced Placement students taking it. Many were simply told “You don’t need to worry about that test; it is not for you.”

We studied hard and tried to do well at MIPS. Much of it entailed starting new systems to be sure we captured missing gaps in care and made sure that all rowed in the direction of value. We made significant financial investments in that. We scored 100 on MIPS. We recently found out our adjustment would be 2.02 percent not the four percent or more that was advertised. This is still meaningful, but the costs of doing well are considerable, and the reduction of incremental payment reduced our margin significantly.

Given these factors, we decided that we needed to get off the MIPS road and get onto the AAPM road. We looked and felt that the Track One Plus ACO was the best choice for us. It gives us an exemption from the unpredictability in MIPS and gives us the chance to earn a five percent increase in our Medicare reimbursement. We are now working with our local hospital in managing our Fee-For-Service Medicare population. That is allowing us to do things that will

improve the health of that population in ways that we would not otherwise have been able to do. But it is important to note, despite its flaws, many of the skills we learned during our MIPS phase are still valuable and still important.

What have we learned?

- The way MIPS has been implemented has not been the way it was planned. A large fraction of doctors is exempt. The few left in MIPS will, on the whole, do very well in their scores, but achieve very little in return, even if they have done everything well that the legislation encouraged them to do. It is now an asymmetric process; the intended large reward for high-scorers is gone, but the intended large loss for those who score poorly is still there.
- The clinical benefits are real in terms of care itself and the care processes that are created to achieve the goals of the program. Those processes can be infrastructure intensive and to participate fully in MIPS is complex and not practical for a small group.
- There are a number of APM models, allowing groups to leave MIPS and move more in the direction of population management. That is good, though ironically it worsens the MIPS problem.
- There has been a recent acknowledgment that CMS should look outside of the FFS Medicare world for models that can be used to encourage the movement from volume to value. The recently proposed Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration is an example of that.

Here are some suggestions that can encourage the movement from volume to value.

- Lower the threshold for excluding groups entirely from MIPS, and thereby increase the number of physicians participating in MIPS. At the same time, in recognition of the fact that smaller groups have fewer resources, MIPS for smaller groups may need to look different from MIPS for larger groups. In other words, give smaller groups a different test, more suitable for their resources, instead of excluding them entirely. Doing so will help move more doctors from volume to value and allow more to participate, while acknowledging that smaller groups have more limited resources to comply with an overly burdensome test.
- Look at other models that will allow groups of doctors that are willing to embrace risk-taking and high value care to do that. APG has a model, known as the “Third Option” that does just that.
- Continue to look at care models outside of traditional FFS Medicare, most notably capitation, in which groups assume financial risk and responsibility. The care given in that model, when the activities of doctors are measured, should count towards the value-based care Congress is trying to promote.
- Even if there are flaws in MIPS, there is value for individual patients and populations of patients and, importantly, the payer for all of this – the American taxpayer – in encouraging data collection and reporting and promoting high-quality and high-value care. The processes that are created to do that will help move Medicare from volume to value. We should find ways of making it feasible for more providers to participate in that process instead of excluding them. Encouraging participation in a manner that is sensitive to a group’s resources will create more providers with the competencies and

ability to know the needs of their patient populations, to better address those needs, to more wisely deploy financial resources, to produce better outcomes, and to better coordinate the care of seniors that sorely need that coordination.

Thank you for allowing me to speak with you this morning. I will be happy to answer questions.

Kurt Ransohoff, MD, FACP

CEO Sansum Clinic, Santa Barbara, CA

Mr. BURGESS. Thank you, Dr. Ransohoff.

I don't see our chairman or the ranking member of the full committee back yet. So, we will proceed with the question-and-answer portion of the hearing. If either the chairman or the ranking member do show up, we will, obviously, yield to them for their statements as well.

And I, again, want to thank each of you for being here.

Many of you have mentioned different milestones along the journey that took us from where we were in the early 2000s to where we are now. I will just say, when I first got here, the goal of repealing the SGR became one my primary focus, and early on it was to repeal the sustainable growth rate formula. I thought if I replaced that with the Medicare Economic Index plus an inflation factor every year, so MEI plus 1 sounded reasonable to me, pretty simple and straightforward. So, that was my original proposal. The Congressional Budget Office threw about \$300 billion of cold water on that idea, and I attracted no supporters, and I literally was pursuing that by myself, I think through two Congresses.

So, that is part of what led to the journey of where we are now. Obviously, things have happened along the way. The PQRS, many of you mentioned having to come to a conclusion at the end of every year and provide a "doc fix". And how many remember PQRS in 2006 was sort of Bill Thomas' parting gift to medicine, if I can use that term? But PQRS was to pay for the "doc fix," right? That is how we got PQRS, and PQRS is one of those legacy programs that now finds itself in MIPS.

One of the largest contacts I get on social media is about a new payment rule for labs in Medicare, and I appreciate that it is causing some stress. That is based upon a provision in what was really literally the last "doc fix" in 2014, a bill called PAMA that, again, provided the dollars to bring us to "doc fix".

So, underscoring everything else, the SGR is gone and we are not having to deal with the "doc fix" at the end of the year, as I think, Dr. Barbe, you mentioned having to go to your banker every year and explain, "Well, it isn't really going to happen." Right? "They say it, but it isn't really going to happen." So, that burden also has been lifted. And now that it is no longer there, we kind of forget that it was something that literally it was the end of every Congress every December of every year that I was here for quite some time.

So, having provided that background, obviously, I am going to ask the easy question first, and I do want everyone to answer. In the tradition of Chairman Dingell, I am going to make this a yes-or-no question. Better off today under the system that we have or were we better off under the SGR legacy?

Dr. Barbe, I will start with you. Better off today?

Dr. BARBE. Much better.

Mr. BURGESS. Dr. Opelka?

Dr. OPELKA. Absolutely.

Mr. BURGESS. And Dr. Rai?

Dr. RAI. We are better today.

Mr. BURGESS. That is an affirmative.

Dr. Parekh?

Dr. PAREKH. Much, much better.

Mr. BURGESS. Affirmative also.

And Dr. Ransohoff?

Dr. RANSOHOFF. A rare opportunity for five doctors to agree.

[Laughter.]

Mr. BURGESS. OK. I wasn't going to do this, but you reminded me. One of my greatest wishes is to someday come into this committee hearing, having five doctors at the table who are going to discuss how economists should be paid.

[Laughter.]

We will save that for another day. This group gets it.

The economists don't think that is funny, and I have tried that on them from time to time.

So, no program is absolutely perfect, and I appreciate, I guess, Dr. Ransohoff, your journey that took you, first, to the direction of the small practice and, then, to the alternative payment method.

And I will also add, as we were going through the discussions that led to this bill finally getting firmed up, I believed it would take 10 years in this process. Once again, I had a simple formula; let's do 10 years with a 1-percent update every year. That seemed like a good fit. Again, the CBO threw a bunch of cold water on that idea, and it was condensed down to 5 years at a 0.5-percent update, which actually got a little further lowered after that. But I always thought it would take longer.

This is a big change, and more than just having the change and having the bill signed, it is important to get it right. And I hope, if nothing else, this hearing today—this is the fourth hearing we have had on the implementation of this law. And if anyone at the agency is listening, I want them to understand this as well. It is important that we get it right. It is not important that we passed the bill and that we had a signing ceremony down at the White House. It is important that we get it right, because, obviously, patients are counting on it. Obviously, doctors are counting on it, and the taxpayer is also one of the variables in this equation that we have to consider as well.

So, I think I have heard the answer to this question during your testimony, but I will ask you for the record. Would it be better for Congress to continue to work with the agency, with the Centers for Medicare and Medicaid Services, to implement the merit-based system as laid out in statute or just scrap it entirely and go back to the drawing board?

Dr. Barbe, we will start with you.

Dr. BARBE. We are eager to continue to work on this. We think it has potential.

Mr. BURGESS. Thank you.

Dr. Opelka?

Dr. OPELKA. Mr. Chairman, quality is a never-ending cycle. We have to continuously work on this.

Mr. BURGESS. That is great. Thank you. I am going to steal that quote.

Dr. Rai?

Dr. RAI. I would agree that we need to continue to work with you on MIPS.

Mr. BURGESS. Dr. Parekh?

Dr. PAREKH. I also agree. In business school, they teach us about continuous quality improvement, and I think that principle applies here, too.

Mr. BURGESS. Yes, sir.

Dr. Ransohoff?

Dr. RANSOHOFF. There is a lot of good to this program, and it should be continued to be worked on.

Mr. BURGESS. I have some other questions, but I will submit them for the record.

Just one last story about the journey that got us here. There was one morning when the then-Majority Leader came up to me, and I was whining about this problem not having been solved. And he said, "Well, Doc, would it be easier if we put everybody into an ACO?" Well, the short answer to his question is, yes, it would be easier, but it wasn't the right thing.

I appreciate the journey that you have been on, Dr. Ransohoff, and I think that kind of told me what, in fact, I was telling the Majority Leader that morning. We are not quite sure about what the journey that different practices will have to take, and it is important for the entire panoply of practices to be able to prosper in the environment.

And I will yield back and recognize Mr. Green for 5 minutes, please.

Mr. GREEN. Thank you, Mr. Chairman.

And thank each of you for joining us today.

MACRA was an important step forward for our healthcare system, building on the successes of the Affordable Care Act. One of the key goals was to further reforms that would promote value over volume and incentivize providers to find new ways to offer more coordinated and efficient care. In order to further that goal, MACRA created the Physician-Focused Payment Model Technical Advisory Committee, PTAC, and to make recommendations to the Secretary for proposals for physician-focused payment models that would help control healthcare spending and improve quality.

Dr. Opelka, can you describe why MACRA and the creation of PTAC was so critical to our efforts toward delivery system reform?

Dr. OPELKA. I think the key here is—and we really appreciate the congressional action to create the physician input into business models—the care models have changed, and they change every year. They have changed over the last 50 years. The payment model has been stuck from 50 years ago. So, we need to take the care model and put a business model on top of it that works, which means that the payer community, particularly in our case the agency, needs to listen to us and figure out how are we going to incentivize quality; how are we going to reach the congressional goal of value by actually putting a payment model that maps to the care model? And having that relationship, the Congress open that door, and what we need now is for an agency that is willing to, and has the resources to, accept that.

Mr. GREEN. Does anyone else on the panel want to comment on how it was working with the PTAC?

Yes, sir, Doctor?

Dr. BARBE. Thanks for asking that. As I mentioned earlier, physicians want to be engaged and involved in this process. PTAC was

created for that very reason. They have received dozens of proposals that come from the ground level, physicians that are practicing that know what will work in their practices, and perhaps in their specialty. And yet, none of these have been adopted by CMS or, really, we think given serious consideration. And these span everything from very focused proposals in GI medicine to reduce re-hospitalization in Crohn's patients, all the way up to the end-stage renal disease that could have a very broad effect on improving care and reducing costs for dialysis patients. So, we think there is great opportunity there if CMS will listen to us.

Mr. GREEN. Any other comments?

[No response.]

Which gets me to my point, I want to turn to the CMS decision not to test many of the models that the PTAC has submitted for testing.

And, Dr. Barbe, you get the first one. Can you expand on your remarks in your testimony about the Secretary of HHS decision not to implement or test most of the physician-focused models that PTAC has submitted for testing? Why is it so problematic for MACRA implementation?

Dr. BARBE. So, the original ideas, these very innovative ideas were brought forth from the ground level. PTAC was designed to evaluate these, look at the merit, look at the rigor, and make recommendations. And they have not recommended positively on all of these proposals, but they have recommended positively on 10. Again, up to this point, CMS has not seen fit to continue to work on those, to dialog and say, "Well, this is what we don't like" or "what we do like about this proposal. If you could change it, maybe we could adopt it." They seem to be interested in coming up with ideas on their own, and I think that is not only reinventing the wheel potentially, but it is not taking advantage of some very creative and innovative proposals that have come forward.

Mr. GREEN. Anyone else?

Yes, sir, Dr. Opelka?

Dr. OPELKA. So, Congressman Green, we did propose to the PTAC. We were early on accepted. We were, then, accepted in a letter by the Secretary for consideration by the Innovation Center. The Innovation Center had a few conference calls with us and one 2-hour in-person meeting on a product that we developed that took almost 5 years in the making. There is no resources and no capability in the Innovation Center to complete a design and, then, to create an implementation and have a sandbox or a pilot area in which to test.

And so, the PTAC has done a fantastic job. The Secretary vetted us. And I think we are the only one that went from the Secretary and was recommended to the Innovation Center, and it died in there because it is just not wired to really innovate. And we really need to turn that on.

Mr. GREEN. Dr. Barbe, or anyone else, has the AMA or any other specialty societies received further feedback from HHS or CMS on why HHS is not testing these models that the PTAC has recommended? Have you gotten any feedback other than—well, I want to hear from Dr. Barbe.

Dr. BARBE. We have submitted just a month ago a four-page letter outlining what we believe are some merits of a few of the very specific proposals that PTAC recommended on up to CMS. And while they acknowledge receipt of those, they acknowledge the work that the PTAC has done, they really have not offered any explanation. As I said, we would be happy to work through PTAC with them to modify, if there was a deficiency they saw in the model and they said the idea is good, but it won't go for this reason. I think we are all eager to work with them. We are 3 years into a 6-year program on this particular issue and still don't have a model that physicians can embrace and use that has been approved.

Mr. GREEN. Mr. Chairman, my time is out, but somewhere along the way HHS should clarify and have coordination between not just AMA, but also the specialty societies, because, as you know, specialties sometimes are different than a doctor down the road. And we need to see whether our subcommittee can maybe encourage HHS and CMS to give feedback and coordinate with you on where we are going with this.

Thank you.

Mr. BURGESS. I don't disagree. A future hearing that would include both the agency and stakeholders on PTAC issue seems like a good idea.

The Chair recognizes Mr. Guthrie, 5 minutes for questions, please.

Mr. GUTHRIE. Thank you very much, Mr. Chairman.

Thank you, everybody, for being here.

And I know you have touched on some of this in your opening statements, but I know that the 5 minutes is kind of limited. So, I want to just go back and give you each a chance to ask—I will do these two questions together.

So, my question is, for each of you, what specifically has each of you done, or are doing, in your own practices to daily set yourselves up for success under MIPS, and if you went through MIPS and out of MIPS specifically? And what can physicians do right now to position themselves to succeed in MIPS?

So, I will just start with Dr. Barbe. Or, no, let me go right to left, since we went the other way. Dr. Ransohoff, I will start with you, then, and go left.

Dr. RANSOHOFF. Thanks. That is an excellent question, Congressman.

I will give an example. We became a patient-centered medical home. We had a long history of capitated care. So, we are a very integrated medical group. But, going into MIPS, even we, who are pretty far along, decided that we needed to have a culture change within our organization. And so, we adopted this PCMH model, which really has changed the way we do things. Our medical assistant, our nurse will, as the patient is coming into the room, will find out have you had a mammogram that we don't know about; have you had a vaccination that we don't know about. So, we can update it in our system. It is a small thing, but it turns out that is actually an important culture change because it has engaged us in a much more team-focused approach to care. So, that is one ex-

ample of how MIPS has sort of propelled us along in what we think is the right direction.

Mr. GUTHRIE. OK. Thank you.

Dr. Parekh?

Dr. PAREKH. Thank you for the question.

I would say that there is a two-pronged approach to answering your question. One is on a personal level, and then, the other one is our professional society. So, within the eye doctor, eye surgeon community, we have, of course, my organization, the American Society of Cataract and Refractive Surgery, and we have the American Academy of Ophthalmology. We work very closely together to develop measures that are relevant to my day-to-day practice and that align very much with what patients want, I think with what you all want, and with what we want in terms of what is best for our patients.

So, part of it is developing outcome measures, which we have, developing cost measures. It is not an easy task. I personally serve on some of these committees. We spend hours and hours and hours on this, but it is hugely important on a global level to have that, your professional society helping to create those measures.

And then, it's like a one-two punch almost. On a personal level, I will tell you, participating in MIPS and getting good scores has not been very difficult. My EMR makes it very simple. I have a coach through my EMR system. We talk regularly. We email regularly. I can keep track of my score of how I am doing this year. And so, having the good measures is very important, and then, having a good EMR system, and then, just putting forth the personal effort to pay attention to those measures. And then, improve my deficiencies, become a better surgeon, become a better doctor, and also keep track of those measures. So, it has been a two-pronged approach.

Mr. GUTHRIE. Thank you.

Dr. Rai?

Dr. RAI. So, to answer your first question, what have we done to prepare for MIPS and MACRA, really, it is redesigning how we practice. The physician is no longer the center of the healthcare system. The patient should be. And we have redesigned all of our practices, both primary care and specialty care, to put the patient in the middle and establish team-based care, making sure that nurse care managers are interacting with patients, making sure that if you have a chronic disease, your visit never ends. It is just how often we connect with you.

And we have also made significant investments in data infrastructure. An EMR without the ability to draw the data in is just a really expensive word processor. And we have had to make significant investments in drawing the data out, but, then, also make significant digital investments that are patient-facing and forward to identify gaps in their care, to establish online scheduling, all of which we have done in this last year.

Your other question, what should other physicians do to prepare, really, it is no longer focusing on the sickness of our patients, but the health of our population. We need to make more investments on keeping people out of the hospital, even out of our clinics, which isn't always financially viable, but we, through MACRA, through

MIPS investments, are rewarded for that. And we have to use those value rewards to redesign how we practice medicine.

Mr. GUTHRIE. OK. Thanks.

Dr. Opelka, we are about out of time. So, go ahead, if you have got a couple—

Dr. OPELKA. Very quickly, for the most part, MIPS does not measure surgical care. So, we do the best we can to help our surgeons get the credit they need for payment purposes, but, then, we try to refocus them on the quality metrics programs that we have separate from MIPS.

Mr. GUTHRIE. OK. Dr. Barbe, do you have just one quick thought?

Dr. BARBE. Our group has been very successful, but we have invested heavily over a decade in order to be successful. I am concerned that some of these programs now simply don't give physicians enough upside opportunity to invest like that in order to be successful.

Mr. GUTHRIE. OK. Thank you.

And I yield back.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back.

The Chair recognizes the gentleman from Oregon, Dr. Schrader, 5 minutes for your questions, please.

Mr. SCHRADER. Well, thank you, Mr. Chairman.

Dr. Rai, why are 58 percent of the practices excluded from MIPS? What is your opinion?

Dr. RAI. I think CMS created those exclusions because physicians felt they weren't ready to participate. But, for MIPS to be successful, for MACRA to be successful, there has to be a plus and a negative. It is a budget-neutral program. So, there has to be a carrot and a stick.

The 58 percent really came from CMS—

Mr. SCHRADER. But why are they excluded? Why are they not ready?

Dr. RAI. Why are they not ready? I think some consider themselves not ready because they have not made the investments or are willing to make the investments or take the risks that are involved in now making that transition from fee-for-service to value.

Mr. SCHRADER. Investments in terms of expensive computers, or whatever, or what are you talking about?

Dr. RAI. I think the investments are multi-fold. I think probably the most significant investment that we have made is in people, in making sure that we redesign how we practice healthcare. It is in staff. It is not only in staff, but in—

Mr. SCHRADER. So, it is basically a decision by those offices not to engage, frankly, in the new era of modern medicine?

Dr. RAI. It is. It is. It is people that would really like to hang on to fee-for-service for as long as they can.

Mr. SCHRADER. All right. All right.

So, I guess, Dr. Parekh, why is MIPS the only option for a specialist? I would understand that you are not a primary home model type of thing, but why is that the only APM? Or why doesn't some other form of APM work for you?

Dr. PAREKH. Again, I will give you my answer, multiple key reasons. First and foremost, most practically speaking, there are no APMs in my area that I could join, even if I wanted to.

Mr. SCHRADER. Sure.

Dr. PAREKH. So, there is just a geographic barrier to that. You will know better than I about the spread of those APMs through the country, but, certainly, in my area it is just not a choice.

The ACOs are very primary care-focused. When I think of how an ACO works and what the potential is to save money and to improve quality of care, it makes the most sense for primary care to be doing that because they are the quarterbacks of the team. They help coordinate the entire ship. My wife is an internist. I mean, we have this discussion at the dinner table all the time.

When we in ophthalmology are trying to improve our patients' care, I mean, think of it from our perspective. I am trying to do a good job on cataract surgery. I am trying to lower my patient's eye pressure from glaucoma, so that they don't go blind. But, if we were in a big model, those measures are likely not going to be used. So, they wouldn't actually do anything for my patients. They wouldn't actually give me a solid, meaningful measure that I could do, I could measure myself; I could say, oh, I am deficient; I want to improve. That is not going to exist because the system is so big. So, I think we lose something when you have such a massive system. The primary care gets the weight of that in these bigger systems and I think the specialists are lost.

MIPS, on the other hand, gives me a measure that directly affects what I do. If I am—

Mr. SCHRADER. Do you interface with primary care systems at all? Is there any primary care system in your geography?

Dr. PAREKH. No.

Mr. SCHRADER. OK. All right. In rural Oregon, we have been able to make that happen. I am not talking to your situation, but just for the sake of the panel and others, there are ways to make APM systems work, ACOs work in rural settings. It is a culture, and after a while you figure out how to do it, like you all are doing as you adopt new practices and stuff.

So, Dr. Ransohoff, you suggested maybe lowering the exclusion threshold in the MIPS program. Could you elaborate on that a little bit? To my investments, I mean, I would assume that the outcomes, whether you are a large practice or a small practice, the outcomes shouldn't really change. If it is patient-centered, you want the patient to be healthy, less readmissions, less time between surgeries, whatever the option is. Could you talk a little bit about that?

Dr. RANSOHOFF. Yes. I think that the main issue is just trying to get more doctors involved in the process. The way it is set up now, in a way what you have is you have a bunch of people who are believers, if you will, and are kind of going down that path, and then, you have a bunch of people who are just saying, "Thank goodness this doesn't affect me," and are not making any efforts to change.

Mr. SCHRADER. Right.

Dr. RANSOHOFF. I think that, in the absence of change, I don't understand how any of this gets to be affordable. And so, I do think

there is going to have to be some change. By lowering the threshold from \$90,000 to some number less than that, you would start a gradual transition. People would know it was coming.

I do think that, as my colleague here in solo practice points out, I think that this is doable. It is just that people don't want to do it.

Mr. SCHRADER. So, maybe some sort of phase-in with the thresholds, so that people can see a path or eventually develop a path going forward?

Dr. RANSOHOFF. Correct.

Mr. SCHRADER. So, the last question real quick, Dr. Barbe, everyone has pretty much referenced electronic medical records and EHR. I am very, very concerned that, while individual practices and groups are making huge investments—originally, there was some money from the Federal Government to help out; gone now. Maybe that is something we should continue or think of strictly for small practices. But I am concerned about the systems—and you guys have alluded to this—not talking to one another. And there is a vested interest, with all due respect to our EHR developers, to keep that system pretty proprietary and pretty unique, so that you have got to buy their stuff. Could you talk a little bit about trying to broaden that out? Is there a role for the Federal Government to require some of these developers to make it easier for doctors to share their information across specialties, primary care, frankly, nutritionists, the whole gamut?

Dr. BARBE. So, yes, we believe the Office of the National Coordinator can facilitate better interoperability. Many groups are trying workarounds now, all the way from health information exchanges to other cloud-based. Dr. Opelka earlier referenced activities of the American College of Surgeons. The AMA has significant activities around an IHMI, or Integrated Health Model Initiative, that we believe has some great potential. But all of those are workarounds because the industry has not made data interoperable and, in fact, has blocked data in many cases.

Mr. SCHRADER. Thank you. And my time is up, but I think that is a critical issue for this committee to address, if we are going to be successful going forward.

Thank you very much, Mr. Chairman.

Mr. BURGESS. Thank you, Dr. Schrader.

I would just point out that the third title in the Cures bill that we were planning on having oversight of the implementation was the electronic health records. We did have the mental health title evaluation earlier this week, I think, or was it last week? But, in any case, that has been held up because a rule has been stuck at the Office of Management and Budget, and we had initially planned to have that hearing in June and it was postponed because of that reason. Then, we are eventually just likely going to have to have the hearing without the rule having been finalized or released by OMB.

I would now like to recognize the gentleman from Illinois, the chairman of the Subcommittee on Energy and Environment, Chairman Shimkus, 5 minutes.

Mr. SHIMKUS. Thank you, Mr. Chairman. This is a great hearing. Tough names out there. So, if I butcher them, I apologize for that.

For Dr. Schrader, I think we do need to look at this as an exemption issue. If this is a movement forward, and there are cost challenges, we ought to get everybody onboard on the quality bandwagon.

I can't remember who mentioned it in their opening statement, but someone, one of you mentioned that high-performers are not getting rewarded. Can you just address that a minute? Because, obviously, you mentioned, I think—correct me if I am wrong—poor-performers are being identified, but high-performers are not being rewarded.

Dr. RAI. Yes, I think both Kurt and I mentioned that. At the end of the day, for the budget neutrality to work, there has to be just as many people involved in this. And that is what the exclusions created, was the incentive was cut in half for high-performers. Because there weren't as many people in there, the threshold was changed. So, from expecting a 4-percent to a 2-percent increase, yet making all the investments to value, is where we felt that high-performers were literally being penalized for making the right investments.

Mr. SHIMKUS. Any more? Dr. Ransohoff, I am going to go with you to the next question, too. So, why don't you answer that also?

Dr. RANSOHOFF. Yes, we have the same issues. We spent probably half—we will get a 2.02-percent reward for getting 100—we probably spent half of that trying to get it. Now we had done that because we thought that the reward would be significantly more, and it is the right thing to do, but there is an economic issue with it.

Mr. SHIMKUS. Yes, and I am going to talk economics a little bit, too. But I want to go back. What intrigued me about your comment to another question was, electronic health records or whatever, EMR, or whatever you want to call them, asking patients about indices that they may not be there for. We have been dealing with that with the opioid issue and trying to change law, so that there is a little more conversation. As you all know, there are catastrophic stories of the firewall between information, which has turned out deadly, and this whole committee has been trying to do things that we can do to address that. So, I applaud that, and hopefully, the legislation that we are moving forward, hopefully, with the Senate concurrence and a presidential signature, will start making that a little more available.

The concern is always going to be data privacy, personal privacy, and the like. So, you are the folks in the field and you are the ones who have to really help us see and help direct us on protection versus sharing of information throughout the practice. Especially if we are doing a patient center, as you guys were mentioning, holistic, with different people around, that information has to be shared throughout the practice. So, excellent point.

I wanted to ask, I wanted to kind of go off, not totally off-script, and I am not trying to get this partisan or political, but in this current world today how much is, what are you paying—how do you want to answer this question. I have always been worried about uncompensated care. Even with a government-run healthcare policy, high deductibles, can you talk to me about—and that is all the time I am going to have. So, whoever wants to talk to me about,

even in a system where we are doing Medicare and Medicaid, that doesn't pay costs, even if we are moving to high performance. So, if we are not paying the cost of care, and then, you have folks, and then, you are eating uncompensated care, that is where I think our system just breaks down. Anyone want to talk about uncompensated care or charity writeoffs, or however you want to define it?

Dr. BARBE. So, what the AMA would like to see is no uncompensated care not from our side, but because that means patients have coverage that will help them get access to care. That is the bottom line here. So, it is not a matter of how we handle uncompensated care. It is how do we get more people covered, so that they can have access?

Mr. SHIMKUS. Quickly, anybody else want to jump in? Everybody else is compensated fully and there are no writeoffs? That is what you are saying? Or you just don't want to go into this debate right now?

Dr. OPELKA. Well, you have opened up a very complex subject matter.

Mr. SHIMKUS. Yes, right.

Dr. OPELKA. The bottom line is that the uncompensated care patients, when they come in to seek surgical care, it is already too late. They are way behind the power curve. And that is the most unfortunate thing. We all see them. We all treat them. We take care of them.

Mr. SHIMKUS. We should take care of them in the internist level or early intervention and provide that care——

Dr. OPELKA. Their cancers are diagnosed late. So, they have a poor outcome. Let's get in front of the disease, and the uncompensated care patients come in a day late and a dollar short.

Mr. SHIMKUS. My time has expired. Thank you, Mr. Chairman.

Mr. BURGESS. The Chair thanks the gentleman. The gentleman yields back.

The Chair will recognize the gentlelady from California, Ms. Matsui, 5 minutes for questions, please.

Ms. MATSUI. Thank you, Mr. Chairman.

And I thank the witnesses for being here today.

We were talking about telehealth, and a group of us on the Energy and Commerce worked together to advance telehealth legislation, legislative and with the administration. As we have worked on legislative efforts, we have found CMS and CBO to be resistant to expanding access to telehealth due to cost concerns. Expansion has often been judged as adding a new service that could be over-billed, rather than taking into account that reducing hospital and ER visits would result in better care that could result from getting patients access to care sooner and more conveniently.

I am encouraged that CMS has taken steps in this recently-proposed rule to expand access to telehealth in Medicare, as this is what we have been working toward. There will be no way to prove success in the Medicare population without covering services. And I am curious to hear from our witnesses about the types of telehealth services that they currently implement.

Starting with you, Dr. Barbe.

Dr. RAI. I would be happy to start.

Currently, in our organization we provide telestroke coverages to rural hospitals.

Ms. MATSUI. OK.

Dr. RAI. We also are opening up very small cities in Wisconsin, northern Wisconsin, so just Ladysmith at the new site, and we would love to provide more services to there. Some of our specialists live 5 to 6 hours from there——

Ms. MATSUI. Right.

Dr. RAI [continuing]. But easily could provide followup services or counseling services. There is not a lot of times in medical specialties especially, such as endocrinology, that we generally necessarily need to examine the patient. We need to be able to have that conversation and counsel that patient, or other services that are not even physician-based. But, unfortunately, we run into the wall with CMS and other payers without an ability to pay for that infrastructure, which does not come cheap. But we have done it with telestroke. We have done it. We have done it very well. We hope to do more.

Ms. MATSUI. OK. That is great.

Anyone else want to comment on that?

Dr. BARBE. So, there are many types of services and sites of services——

Ms. MATSUI. Right.

Dr. BARBE [continuing]. That are actually prohibited from participating in telehealth or digital medicine. We can start by getting rid of some of those restrictions. We can start by unbundling some of these payment codes, so that we can charge differently for consults versus remote patient monitoring.

Ms. MATSUI. Right.

Dr. BARBE. My particular group is very robust in what we call virtual care, which is digital medicine, and we put monitoring devices in patients' homes. We will even run the internet to their home, because in rural southern Missouri many don't have that. So, there are a lot of things, but we can't do this because there is no direct payment. The only reason we can do it now is we are in some risk-sharing arrangements.

Ms. MATSUI. All right. Anyone else here?

Dr. OPELKA. Just very quickly, where there are capitated environments, all these barriers to payment go away, and telehealth actually becomes very creative and innovative. In a capitated environment, in my former practice we dealt with rural, like was mentioned, but we also dealt with prisoners, and putting telehealth in the prison became a very effective way of getting better care to the prisoner, rather than having to transport somebody with all kinds of guards and other security. Telehealth was a savior.

Ms. MATSUI. OK. Let me just go on. One of my legislative efforts with Representative Bill Johnson on Energy and Commerce is H.R. 3482, which would remove originating site and geographic restrictions on telehealth in Medicare. And the steps CMS has taken to pay for virtual check-ins is very much in line with this idea. We passed a limited version of that bill for opioid service in the House opioids packages, and I hope the Senate will move to take this important legislation. And I really do look forward to having it expand further, and I think it would be helpful for all of you.

I have been working to advance interoperability between electronic health records, and the proposed rule has implemented a performance measurement in order to promote interoperability. I guess, Dr. Opelka, you have talked about this. What success have providers had in working toward a goal of interoperability? Do you feel that the implementation of MACRA has been helpful?

Dr. OPELKA. I don't know that MACRA itself has actually drawn attention to this. When we moved away from dealing with the EHRs and we created a patient cloud, and we began moving data into the cloud environment, in which we could represent information either to a patient or to a clinician from wherever that patient was seen, those models are now emerging separate from the EHR vendors. It is making a huge difference in care in those environments. That is the direction we need to go in, and that is where we need to actually educate the government to help us push incentives that drive us more to a patient cloud environment, rather than to say, this hospital, this EHR, it is this patient and all the hospitals they get care in.

Ms. MATSUI. Right. OK.

I think I have run out of time. I yield back. Thank you.

Mr. BURGESS. The Chair thanks the gentlelady. The gentlelady yields back.

The Chair recognizes the gentleman from Ohio, Mr. Latta, 5 minutes for questions, please.

Mr. LATTA. Thank you. Thank you, Mr. Chairman. I want to thank you for the hearing today.

And I want to thank all of you for being with us today. Because I am sitting here looking at you thinking to myself of all the patients you would be seeing right now in the time that you are taking to testify before us on this important matter.

One of the great things that we get to do, we travel around in our districts. We talk to our docs back home. And we also have the ability to see a lot of the third-year, four-year medical students from our states come through. They are working on a lot of their specialties and everything else, but, at the same time, they kind of bring up with you all the sundry things that they are going to have to be doing to practice medicine.

And I wonder if you all would mind answering a question for me, just going down the line, if you wouldn't mind. How much time do you take out, if you took a percentage, that you are practicing medicine or you are doing the administrative side of your job?

Dr. BARBE. I can answer that very precisely. The AMA has done two studies. It shows that physicians spend about two hours in front of their computer screen or doing other paperwork for every hour they have in direct clinical contact. We did a second study that shows, for primary care physicians, they spent 60 percent of their day in non-direct-patient-care activities.

Dr. OPELKA. And it is roughly about 20 percent of their time doing administrative burden.

Dr. RAI. It is ballpark around that same number. We at our own organization started to look at EMR utilization after 5:00 or 6:00 p.m., when they log in from home after dinner, and how long they are on it. A significant amount of our primary care physicians are

logging in late at night to complete their day, which is definitely leading to a nationwide situation with burnout.

Dr. PAREKH. I will echo the comments. I mentioned earlier my wife is an internist, and the kids go to bed around 9:00 p.m. and we get on our computers.

Dr. RANSOHOFF. We have done the same kind of study. We see that internists, it varies somewhat by specialty, but in primary care it is not uncommon for doctors to spend 20 hours a week after hours doing documentation on the computer.

Mr. LATTA. And I know they are calling votes on us right here. I am going to ask just one question then. The clinical data registries and the certified EHRs that are envisioned by MACRA as serving as critical reporting mechanisms for providers to interact with the Medicare, would these represent a decrease in that administrative burden then? And just go down the line.

Dr. BARBE. They haven't yet. The EHRs still just don't work for physicians. There is too much point, click, move from one field to the next. Even in the certified technologies, which we have, we are still burdened significantly by that.

Dr. OPELKA. So, the clinical data registries, we run about seven international registries. They actually pull data in and generate knowledge, and that knowledge is delivered at the moment of care that allows for clinical decision support, that allows for better care, higher quality, et cetera. So, while they may take on time, they actually reduce burden and improve patient outcome. So, they are very welcome.

Dr. RAI. I would echo that. The registries are welcome. They help us identify gaps in care that patients may need on an active basis, on a more timely basis, and the ability to access a patient to make sure that we get in front of them before they get in front of us in an acute situation.

Dr. PAREKH. As I mentioned in my testimony, the Academy of Ophthalmology created the IRIS, I-R-I-S, registry, and it has been a huge help. I will give you an example. Let's say, 2 days ago, I was doing surgery. My EMR records the date of the surgery on the right eye, for example. And then, when we see the patient back, of course, we record how the vision is doing. And one of our measures is, is the patient 24/40 or better within 90 days? So, it is an outcome measure, like I said, very important to our specialty, very important to our patients. And so, as soon as that vision reaches that threshold, the EMR automatically captures that data. The point is, we are getting outcomes data and it is very little additional work because the registry is able to grab that info without me typing it in again for the registry. So, it has been great.

Dr. RANSOHOFF. There is nothing faster than ineligible handwriting that is not shared with anyone.

[Laughter.]

And I practiced in those days. The computer systems that are out there now are more time-consuming. I do think they are much better.

I prescribed recently—the patient was on two unusual medications, and they computer said there is going to be a drug interaction. And so, there are real benefits to it, but it is definitely more time-consuming.

Mr. LATTA. OK. Well, Mr. Chairman, my time has expired, and I yield back.

And I thank our witnesses again for spending time with us today. Thank you.

Mr. BURGESS. The gentleman yields back. The Chair thanks the gentleman.

The Chair does acknowledge there is nothing faster than bad handwriting, particularly if you are lefthanded.

The Chair now recognizes the gentlelady from California, Ms. Eshoo, 5 minutes for questions, please.

Ms. ESHOO. Thank you, Mr. Chairman.

And thank you to the witnesses. You represent so many that practice medicine across our country in the different disciplines, and have headed up, and do head up, organizations that are representing them.

I would like to go to Dr. Rai and Dr. Ransohoff with this question. Earlier this month, CMS released a proposed rule that estimated that 42 percent of physicians participating in Medicare will need to comply with MACRA. So, my question to both of you is, with so many physicians that are exempt from both APMs and MIPS, has CMS undermined the original intent of MACRA? Would that be your take? And with so many physicians exempt, will MACRA meet the original payment reform goals it set out to achieve?

Dr. RAI. I do believe CMS has gone against the intent of MACRA with the exemptions. For this to work, for us to truly move to value, the intent of MIPS, as one of my colleagues has been quoted to say, MIPS was the on-ramp to value and CMS has created an exit ramp.

Ms. ESHOO. Why do you think they are doing this?

Dr. RAI. Change is never easy. The change of going from fee-for-service to value, to taking risks—

Ms. ESHOO. Oh, we have been doing that for a long time. This isn't exactly something that happened in the last 90 days. We have been in transition since I first came into the Congress on this thing, and I have been here for a while.

Dr. RAI. I don't disagree with you at all. The legacy programs did not have the exemptions. And now, all of a sudden, we are exempting people, and it is truly preventing—it is another kick-the-can-down-the-road. It is becoming SGR 2.0 if they continue that behavior.

Ms. ESHOO. Well, how do you think CMS can improve the MIPS implementation?

Dr. RAI. Implement it as it was written. Really implement what you passed.

Ms. ESHOO. Great. Good answer. Good. All right. Well, that is confidence in the work that we have done, Mr. Chairman.

To Dr. Opelka and Dr. Parekh—is it “Parak” or “Paresh”?

Dr. PAREKH. Parekh.

Ms. ESHOO. Parekh.

I have heard from physicians in my congressional district—it is the Silicon Valley district in California—that those in small practice and who practice specialty care face barriers in participating

in MIPS. Do you face barriers, as some of my physicians have reported? And if so, what are they?

Dr. PAREKH. Thank you for the question.

As an ophthalmologist, again, I feel very lucky. We have amazing professional societies. We have been working for a long time, as you said, coming up with measures. We have been preparing for this moment for a while, coming up with outcomes measures, coming up with process measures, creating cost measures, having a registry. So, I am very fortunate—knock on wood, I thank our professional societies—it hasn't been that hard for us in ophthalmology.

Ms. ESHOO. Well, that is good. Do you know Dr. Chang?

Dr. PAREKH. Dr. David Chang.

Ms. ESHOO. Dr. David Chang, yes.

Dr. PAREKH. Yes, he is one of my very good friends. In fact, he knew that I was coming today and sent me a very kind email.

In ophthalmology, I think our numbers to some extent back up what I am saying. I think people who participated in our registry, I think 85 percent got a score of 100, getting the 2 percent that was mentioned earlier, and I think 99 percent got some type of bonus. So, again, we have been working very hard at this, and I think it is blossoming.

Ms. ESHOO. Would you recommend anything to us that would lessen the burden on physicians, so that you can more actively participate in MIPS or do you think it is just working swimmingly?

Dr. PAREKH. I think there is always room for improvement.

Ms. ESHOO. Always, yes.

Dr. PAREKH. Like I said, it is a continuous quality improvement mindset that we have to have.

Ms. ESHOO. But do you have something, anything specific? Anyone have anything specific?

Dr. OPELKA. Sure. So, this whole matter of participating or exclusions, if you don't measure what matters, putting money and investments into something that is senseless, nobody wants to participate.

Ms. ESHOO. And that is what we are doing?

Dr. OPELKA. So, all the surgical specialties, all of them, including ophthalmology, the majority of their measures have nothing to do with surgical care.

Ms. ESHOO. Wow.

Dr. OPELKA. They are measuring primary care. So, it doesn't surprise me that primary care says everyone should be in, but it also doesn't surprise me when surgery care says, "It doesn't matter to the patients I am treating. So, why am I spending money in my practice to send CMS tobacco cessation and immunization rates?" Nobody comes to me as a surgeon with breast cancer to talk about those things. We are not measuring what matters. And so, as long as we are going to measure silly things, everyone is going to say, "I want to be excluded." If you want to measure what matters, put me in. Put me in, coach. I want to play. But that is not what we are getting.

Ms. ESHOO. Well, I think that that is highly instructive to us, Mr. Chairman.

Mr. BURGESS. That is the reason we are having the hearing.

Ms. ESHOO. Yes. Well, that is what happens in hearings.

Mr. BURGESS. And I appreciate your—

Ms. ESHOO. But what I am suggesting is that we work with CMS to get rid of what was just described as the—did you use the word “silliness”?

Dr. OPELKA. Yes.

Ms. ESHOO. OK. Thank you to all of you. You are the healers of the Nation. So, thank you for what you have devoted yourselves to, and taking on the extra responsibility of heading up organizations.

Mr. BURGESS. If the gentlelady will conclude her soliloquy—

Ms. ESHOO. Thank you.

Mr. BURGESS [continuing]. We have about a minute left on a vote on the floor.

Ms. ESHOO. I yield back.

Mr. BURGESS. I am going to recess after I acknowledge the presence of Dr. Boustany, former Member of Congress and member of the Ways and Means Committee. We appreciate your attendance here today.

And we will stand in recess until after this vote.

[Recess.]

Mr. GUTHRIE [presiding]. The committee will come back to order. Thank you.

There will be other members that are voting and will be back shortly to ask questions, but we are going to continue the question period.

All right. The Chair recognizes Dr. Bucshon for 5 minutes to ask questions.

Mr. BUCSHON. Thank you, Mr. Chairman. I appreciate that.

And thank you to all the witnesses for being here. I was a cardiothoracic surgeon before coming to Congress, and this is critically important for our patients at the end of the day, right? And that is what I try to focus on.

As you know, the participation in MIPS is low. Everyone outlined roughly 60 percent of physicians are excluded from the program, leaving only \$118 million of the \$70 billion baseline for incentive payments for practices. Participation in the alternative payment models in MACRA is even smaller, with only 5 percent of physicians enrolled in an APM. CMMI has not approved a single APM submitted from PTAC, and PTAC cancelled its June meeting due to lack of APMs to review.

I am interested in ways to increase participation in and the number of APMs, which is why I introduced the Medicare Care Coordination Improvement Act, H.R. 4206, which three of you on the panel's organizations have signed a letter in support of—and I will get to that in a minute—which would encourage development, testing of participation in APMs by exempting practices from the volume and value prohibitions in the Stark law. After all, how can practices deliver on value-based care if they cannot remunerate their physicians based on value?

Mr. Chairman, I ask unanimous consent to submit the letter to the record.

Mr. GUTHRIE. Without objection, so ordered.

Mr. BUCSHON. The American College of Surgeons, the American Medical Association, and AMGA, among many others, have signed onto the letter.

Basically, it says they are in strong support of the act that we introduced and “The legislation would substantially improve care, coordination for patients, improve health outcomes, and restrain costs by allowing physicians to participate and succeed in alternative payment models.” The bill would modernize the Stark self-referral law enacted nearly 30 years ago.

The things that it would do is provide HHS with the same authority to waive the prohibitions of the Stark law and associated fraud and abuse laws for physicians seeking to develop and operate APMs, as was provided for ACOs in the Affordable Care Act; remove the volume or value prohibition in the Stark law, so that physician practices can incentivize physicians to abide by best practices and succeed in the new value-based alternative payment models. This protection would apply to physician practices that are developing or operating an alternative payment model, including the advanced APMs, APMs approved by the physician-focused payment model, the Technical Advisory Committee, MIPS APMs and other APMs specified by the Secretary; and finally, ensure that CMS’s use of current administrative authority promotes care coordination, quality improvement, and resource conservation.

I guess I will ask the question of everyone. How do you think changes to the Stark law would help physicians coordinate and improve care and help MACRA succeed? And how important do you think that would be in the overall success of what we are trying to do with the MACRA legislation and, also, as you have noted, transition to an outcome-based, patient-centered-based way to reimburse providers?

I will just start that. If any of you aren’t aware of what we have done, that is OK. But we can start with the surgeons.

Dr. OPELKA. Thank you very much.

First of all, yes, we are in strong support of this effort. Specifically, the way that Stark is written, you can be held accountable without intent, and that is a problem. So, when we have alternative payment models with shared savings opportunities between all the parties, legal counsel, when they review these contracts, become extremely worried about how clean are these waivers or exemptions from Stark. They have got to be bulletproof because Stark is so broad and overreaching, it is easy for a court to interpret things different than your own counsel interpreted them.

For that reason, when we go to these alternative payment models where there are parties that will be involved in shared savings, or whatever different payment models are applied, we need to be sure that there is clean, crisp lines that exempt or waivers that are provided for Stark, so the parties can come together. That is really what we see. When we put our own APM forward to PTAC, we included the need for Stark waivers and the exemptions. But we agree with you and fully support what you are doing.

Dr. RANSOHOFF. In order to have an ACO, particularly an ACO like this that requires risk-taking and risk-sharing, you need to get a group of physicians together who are willing to work together and share the risk and, also, generally, a hospital. So, you need all

of those parties to do that. Then, these laws become a serious impediment to doing that. Just the legal expenses of trying to make sure it is even OK to have a meeting become daunting. So, I think if you are going to encourage doctors and hospitals to try to take risks together in a fee-for-service world, you do need to look at the regulatory barriers that exist.

Mr. BUCSHON. All right. Thank you.

Beg your indulgence, Mr. Chairman.

Anyone else have any comments quickly? Anyone else? Yes?

Dr. RAI. Stark made sense in a fee-for-service environment, but if we are truly going to move to value, we need regulatory relief, as explained by my colleagues.

Mr. BUCSHON. OK. Thank you. I appreciate that.

Thanks, Mr. Chairman. I yield back.

Mr. GUTHRIE. Thank you. The gentleman yields back.

The Chair now recognizes Mr. Griffith of Virginia, 5 minutes for questions.

Mr. GRIFFITH. Thank you very much, Mr. Chairman. I appreciate it.

I appreciate you all being here. With two votes series disrupting the committee, it is tough as witnesses, and I do appreciate your patience.

Let me echo what my colleague just said about the Stark Act. I think it is outdated probably in more ways than most people do. And I find it inhibits some collaboration in rural areas where we are underserved already. And why would we put barriers up?

Does anybody disagree with that statement? I am looking at the entire panel. Just for the record, none of them disagrees with that statement.

All right. Let's see. Given that, now I have got a question that we want to get on the record. On June 29th, CMS allowed MIPS participants to see their performance score based on 2017 reporting. Would each of you please share what your scores were?

Dr. RAI. I would be happy to start since I brought mine with me.

Mr. GRIFFITH. All right. That would be fine.

Dr. RAI. We bill under four Tax ID Numbers because of how we are regionally divided. Three, we scored 100, and on the fourth one we had a 97.

Mr. GRIFFITH. OK. Anybody else weigh in who knows? Yes, sir?

Dr. PAREKH. I like your question because it also relates to the previous issue of physician participation. I was in a big group practice and I decided to start my own practice. And so, it was the end of 2015 and into 2016 that I was doing that. The 2017 measurement, what you are asking about, is based on your surgical volume or your volume at the end of 2016, but that is when I was starting my practice.

I knew, of course, about our Academy's IRIS registry. I knew myself. I knew that I could do a good job on those measures, but there was no opportunity for me to participate. I couldn't opt in. I couldn't believe that I couldn't opt in. So, I asked multiple people. I am like, "Are you sure I can't opt-in? I would love to do this. This is great. That is a good measure." Multiple people assured me I could not.

Mr. GRIFFITH. OK.

Dr. PAREKH. So, unfortunately, I was not eligible, even though I wanted to be.

Mr. GRIFFITH. All right.

Dr. RANSOHOFF. As I have said before, we bill under a single Tax ID Number, and we did get 100.

Mr. GRIFFITH. OK. And last, but not least.

Dr. OPELKA. I am retired from practice.

Mr. GRIFFITH. Yes? So, no data? All right. I appreciate that. Thank you so much.

My concern, of course, is rural areas, as I mentioned before, when I was talking about the Stark Act. So, when we are looking at rural areas, can you describe or can any of you illuminate us on the challenges of physicians practicing in the rural areas and the pressures they face to remain in practice? And how do the legacy programs add to those burdens? I know a lot of the burdens they have already. But how do the legacy programs add to those burdens, and has MIPS eased those burdens? And even if it has eased them a little bit, what else can we be doing to help our rural friends?

Dr. Barbe?

Dr. BARBE. Maybe I will weigh in on that first. So, I was amazed when MACRA passed and we were looking at MIPS, and we had a lot of physicians come out of the woodwork and say, "Oh, my gosh, how are we going to comply with MIPS?" And I thought in my mind, well, have they not been doing the legacy programs already? And the answer is, no, they hadn't. Hundreds of thousands of physicians didn't participate in all three or didn't participate successfully. So, there are a lot of physicians that are now working to make this transition.

Specifically, with regard to rural, Dr. Opelka said it very well. We need meaningful measures that relate to that individual physician's practice. We need to make them easy to capture, and we need to make them, if you will, activities that are applicable across more than one of those dimensions of MIPS. If you have got a diabetic patient and you are changing your processes and you are improving care, and you are using an electronic record, why don't you get credit across all three domains?

Mr. GRIFFITH. All right. Yes, sir?

Dr. OPELKA. Very quickly, the trauma program is a classic example where we have Level I, II, and III levels of service. Typically, in the rural environment we are dealing with a Level III. The number of standards they need to meet are significantly less than the 200-plus standards for a Level I. So, you need to tailor measurement down to the point of care and the care model that that environment has. The MIPS program does not do that. It is a one-size-fits-all program. So, the rural element is no different than, in surgery, it is no different than in the city. They are not meaningful and fit for purpose. And therefore, the surgeons pay attention to it for purposes of payment, but not for the purposes of quality of care.

Mr. GRIFFITH. OK. Anybody else? Yes?

Dr. RAI. We operate many rural clinics, but because they are part of a larger multi-specialty group, we are able to spread our infrastructure more efficiently to them.

And to your other question about was it easier under MACRA to submit versus the legacy programs, I have talked to our quality department. It was slightly easier this year to submit to CMS. The mechanism of submitting all three at once was easier than the previous legacy format.

Mr. GRIFFITH. So, it was a little bit better?

Dr. RAI. A little bit better, yes, sir.

Dr. PAREKH. I would echo all these comments. Understand that rural medicine is very different than urban/suburban. And I know in Washington oftentimes people talk about a bubble in Washington, but coming from central Pennsylvania, it is a very different environment here. Let me tell you, there are hospitals where I can't get internet service. Just think about that statement. And my EMR, of course, is a cloud-based EMR. This is a true issue. But, again, I think MACRA has certainly helped, to answer the second part of your question.

Mr. GRIFFITH. Other parts of our committee are trying to work on those internet issues.

Dr. Ransohoff?

Dr. RANSOHOFF. Technically, right now for someone who had just done nothing, MIPS is actually better, just by the algebra of it initially, because the cut would have been less.

But I agree with my colleagues, and I have said previously I think for small practices in rural areas they just need a different—they need relevant standards that resonate with their practice, but they probably need to have a different test, so that they can participate. Fewer measures I think would be a very reasonable approach.

Mr. GRIFFITH. All right. Thank you very much. I appreciate it. And my time is up and I yield back.

Mr. GUTHRIE. Thank you. The gentleman yields back.

The Chair now recognizes Mr. Carter from Georgia for 5 minutes for questions.

Mr. CARTER. Thank you, Mr. Chairman.

And thank all of you for being here.

Before I begin my questions, I have to say this. Earlier in the hearing there was a conversation about doctors' handwriting. And I just want to say, I want to represent my profession as a practicing pharmacist for over 30 years. So, you get it? You understand what I am saying.

[Laughter.]

Anyway, I couldn't resist that and I apologize. Too many times have I struggled to understand what a doctor was writing.

I wanted to talk to Dr. Rai. OK, I am sorry. I know I butchered that.

But, nevertheless, as a pharmacist, I am a member of the Doctors Caucus. We had sent a letter to CMS earlier this month about MACRA and MIPS implementation and the \$500 million that had been authorized to ensure positive payment adjustments. But one of the things that we have run into is that we just don't have enough physicians who are participating. And I just wanted to ask you. CMS estimates that it is over 60 percent that aren't participating. What are the obstacles? What are some of the obstacles that are preventing or prohibiting providers from switching to this?

Dr. RAI. I think some of the obstacles are inherent to how they have been practicing medicine and how their own structures have been developed over time. Some may say they have not followed the legacy programs, as was mentioned earlier. So, they have not actually implemented the EMR or using it in a meaningful way. They have not developed patient-centered medical homes or have the ability to tap into registries. There are a variety of reasons why people are not participating.

But for us to truly move to value, we need everybody to participate. MACRA was written to be a carrot-and-a-stick program. So, for it to work, everybody has to be in.

Mr. CARTER. I suspect that I would be correct to say that it is worse in rural areas than it is in urban areas. Is that correct?

Dr. RAI. I haven't seen CMS's distribution of who is not participating, but I think it is across the board. I think you will see it in small single specialty in a very urban area. But, yes, you will probably see it a lot in urban areas that don't have a system infrastructure supporting them.

Mr. CARTER. OK. Can you describe very briefly about some of the investments that your organization has made in order to participate in this?

Dr. RAI. I can break the investments into three categories, the first being people. The most important category in healthcare is continuously investing in people. Team-based care is not inexpensive—nurse care managers, extra medical assistance, making sure the physician or the provider is surrounded by the best people to take care of their population, not just the patient that is in front of them that day.

The next area is, like I mentioned, an EMR is only as good as you can draw the data out of. So, our largest area of investment in the EMR is not really the EMR anymore. It is digital platforms to draw the data out, to analyze it, to hopefully someday get access to claims data, which we need, to be able to look at a risk population and predict what is going to happen to a patient before it happens to them.

And the third area of investment is that digital platform that is patient-facing. Our patients want access to their record. It is not our medical record; it is their medical record. It is creating environments for them to interact with us in virtual care, like we launched this year, where they don't have to come into the office.

Those have been the three categories of investments that we personally made to make sure we are successful not only with MACRA, but with value down the line.

Mr. CARTER. Right. Thank you.

Dr. Parekh, I wanted to ask you, in your testimony you had mentioned that MedPAC had made the recommendation that MIPS should be replaced with a voluntary value program that might be phased in over time. And I just wanted to ask you—and in full disclosure, I agree with you; I don't agree with MedPAC. I think that would be the wrong route for us to go. I think we are headed in the right direction with this. We ought to figure out a way, I think, if not to incentivize, then to require physicians to do this. And I don't like that. I don't like the heavy-handed government, particu-

larly in healthcare. But, at the same time, I am convinced we are moving in the right direction.

I just wanted to ask you, what are some of the challenges to developing outcome measures in the practice of medicine?

Dr. PAREKH. It is just hard. It is hard to do. You have to have a clean measurement. You don't want all these other comorbidities that are "messing up your outcomes". So, let's take cataract surgery, for example. If I have a patient who has got severe blinding macular degeneration at baseline, and then, they have developed a cataract on top of that, as bad as it originally was, now it is worse. So, I take their cataract out and I get them maybe to 2400, which is the big "E", legal blindness still. They are ecstatic, but my measure might look bad because, "Oh, Dr. Parekh, this patient, you operated on them and they are legally blind." So, things like that, those subtleties, the devil is in the details.

Mr. CARTER. Right.

Dr. PAREKH. Those subtleties make all the difference. So, coming up with those kind of clean outcomes is very hard to do.

Mr. CARTER. Right.

Dr. PAREKH. And so, there are certain surgeries that lend themselves to that, but others that don't.

Mr. CARTER. I am out of time. But I want to thank all of you for your efforts in moving this forward, because I do believe it is we are headed in the right direction with this.

And I yield back.

Mr. GUTHRIE. Thank you. The gentleman yields back.

Seeing there are no further members wishing to ask questions, I would like to thank you all for being here today. As somebody mentioned earlier, you are missing a lot of patients today to be here to inform us, but it is important that you do.

And I would like to submit the following documents for the record: American Academy of Dermatology Association, letters from the American Academy of Family Physicians, the American College of Physicians, Connected Health, American Society of Clinical Oncology, Infectious Disease Society of America, and Medical Group Management Association.

Mr. GREEN. No objection, Mr. Chairman.

Mr. GUTHRIE. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. GUTHRIE. Pursuant to committee rules, I remind members that they have 10 business days to submit additional questions for the record, and I ask that witnesses submit their response within 10 business days of receipt of the questions.

Mr. GREEN. Without objection. Mr. Chairman, I would just like to recognize a family from my district, the Garcia family. We spend a whole lot of time in these committee meetings. But I thank them for coming here.

Mr. GUTHRIE. Welcome. Welcome to Washington. Thanks for being here.

So, without objection, the subcommittee is adjourned.

[Whereupon, at 12:13 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

We're meeting today to discuss one of the great bipartisan success stories of this Committee, the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA. MACRA built upon the successes of the Affordable Care Act to improve the quality and efficiency of the Medicare program, and of our health care system more broadly.

The ACA took major steps towards improving the quality of our health care system by creating new models of health care delivery within the Medicare program. These new payment and delivery models focused on transforming clinical care and shifting from a volume- to a valuebased care model, such as Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs).

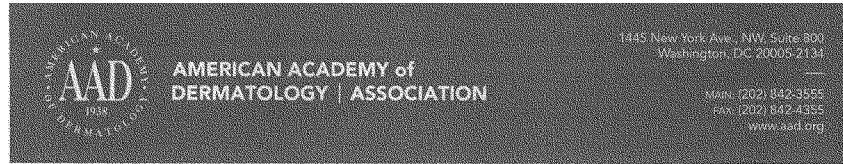
With MACRA, we are entering the next phase of delivery system reform. MACRA builds on reform efforts by offering opportunities and financial incentives for physicians to transition to new payment models known as Advanced Alternative Payment Models, or AAPMs. AAPMs must meet a number of criteria, and requires clinicians to accept some financial risk for the quality and cost outcomes of their patients. Physicians can join existing and successful models that qualify as AAPMs, such as ACOs and the Comprehensive Primary Care Plus (CPC+) model, which we will hear about today. They can also develop their own models, known as Physician-Focused Payment Models.

MACRA also created the Merit-Based Incentive Payment System, or MIPS. This is an alternative path for clinicians to make the shift away from a volume-based system to a valuebased system. It focuses on quality, value, and accountability.

Our witnesses practice in a variety of settings across the country and represent diverse expertise and training. They each have a unique perspective to share with us regarding the implementation of MACRA. I know that some of our witnesses have concerns about how MIPS has been implemented by CMS, in particular the decision by the agency to exclude 58 percent of providers from MIPS requirements through the low-volume adjustment. I share these concerns and want to learn more about how CMS's decisions may impact successful MACRA implementation going forward.

I want to thank you all for your commitment to delivery system reform-it is only through the sustained commitment of the leading physician organizations and clinicians such as yourselves that we can hope to bend the cost curve and create a system that truly rewards high value care. I hope that after hearing from our panelists today, we will all have a better understanding of the opportunities and challenges faced by physicians in the MIPS program.

Thank you, I yield back the remainder of my time.



U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
Hearing on "MACRA & MIPS: An Update on the Merit-Based Incentive Payment System"
Thursday, July 26, 2018
American Academy of Dermatology Association
Statement for the Record

Chairman Burgess and Ranking Member Green, on behalf of the American Academy of Dermatology Association (Academy), which represents more than 13,800 dermatologists nationwide, thank you for your leadership in convening the hearing on "MACRA & MIPS: An Update on the Merit-Based Incentive Payment System." The Academy is pleased to submit the following statement for your consideration.

The Academy is committed to excellence in the medical and surgical treatment of skin disease; advocating high standards in clinical practice, education, and research in dermatology; and supporting and enhancing patient care to reduce the burden of disease. We applaud you for continuing to monitor the implementation of Medicare Access & CHIP Reauthorization Act (MACRA) and ensuring that the needs of physicians and other healthcare providers, as well as those of our patients, are taken into account as the requirements of the Quality Payment Program (QPP), and the Merit-Based Incentive Payment System (MIPS) specifically, are developed.

We greatly appreciate the substantive progress that was made in 2017 to implement the Quality Payment Program (QPP) under MACRA in a manner that provides regulatory relief to physicians. The Centers for Medicare and Medicaid Services (CMS) increased the threshold for individual Merit-Based Incentive Payment System (MIPS) eligible clinicians or groups to be considered exempt, excluding from the new system those with up to \$90,000 in Medicare Part B allowed charges or up to 200 Part B beneficiaries. CMS added a new hardship exception for clinicians in small practices (15 or fewer clinicians) under the Advancing Care Information (ACI) performance category, and CMS also provided relief to physicians who faced disasters such as the California wildfires and the devastating hurricanes of 2017. Finally, as MACRA requires 25 percent of the MIPS final score be based on performance in the ACI performance category, CMS made an important modification to the performance score changes to give 10 points for participating in a specialized registry such as the Academy's Qualified Clinical Data Registry (QCDR), DataDerm. Rewarding physicians for participating in a QCDR not only allows physicians to report on performance measures that are approved by CMS, but it also promotes QCDRs' development of quality measures that are relevant and meaningful to practicing physicians.

As the Subcommittee convenes this hearing today, there are four issues that the Academy would bring to the Subcommittee's attention.

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Cost Performance

First, the Academy is concerned that it is premature for physician payment to be based on cost performance given the flaws in the current patient attribution methods. For 2018, CMS finalized a 10 percent weight for the cost performance category in the final MIPS score. This is intended to ease the transition to a 30 percent weight for the cost performance category in the 2021 MIPS payment year. For the 2018 MIPS performance period, CMS is adopting the total per capita costs for all attributed beneficiaries measure and the Medicare Spending per Beneficiary (MSPB) measure, both of which were adopted for the 2017 MIPS performance period.

However, many physicians have reported problems with the current attribution methods. For instance, a dermatologist provided the most Evaluation and Management services to a patient during the reporting period. That patient suffered from recurring mental health problems that resulted in admission to an inpatient facility. The costs for hospitalization and other care associated with the mental illness were attributed to the dermatologist. This indicates that the attribution method is clearly flawed, and we understand that the appeals process does not seem to be functional. Until CMS corrects the attribution method to ensure that costs of care not associated with the condition being treated are not attributed to the specialist caring for the patient, the cost performance should not be given a weight.

Additionally, it is very difficult for physicians to look-up their cost score prior to their reporting cycle. Physicians are not aware of what this score will be nor what they can do to positively affect cost performance. CMS needs to make this scoring process more transparent and not grade physicians on their performance without providing details on how they can actually improve their cost scores.

QCDR Measure Approval Process

Second, improvements to the QCDR measures approval process are needed to achieve efficiency, transparency, and connection to clinical evidence. The current process is characterized by unreasonable deadlines, unexplained rejection or consolidation of measures, an inconsistent review process, and disjointed review. Consideration of time to gather data and provide evidence of measure and performance gaps during the review process would allow for continued meaningful measures for specialists. Further, the Academy opposes applying the MIPS Call for Measures process to QCDR measures. The MIPS process is slow (6 months between measure submission and publication of the final list), cumbersome, and ill-suited to specialty care. The Measurement Application Partnership (MAP) process hinges on National Quality Forum (NQF) endorsement, a separate lengthy process with few standing committees that include Dermatology topics. Historically, the Measures Advisory Panel lacks the expertise to review the clinical importance and evidence for specialty measures. The measure approval process must be based on specialty-relevant clinical expertise and rationale. Instead of applying the MAP process to QCDR measures, we have urged CMS to improve the current QCDR measure review by implementing a transparent review process with clear criteria about the acceptability of measures and clear timelines for CMS review. Harmonization is a worthy goal that should be addressed

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outside the measure approval process. We appreciate that CMS has met with us a number of times to hear our concerns on this important issue and hope that needed improvements can be made.

Data Blocking

The ability of QCDRs to access patient information from electronic health record (EHR) vendors is crucial for such registries to not only achieve their missions of improving quality of care, but also to foster the development of quality measures that are relevant and meaningful to practicing physicians. The passage of provisions in the 21st Century Cures Act (Pub. L. 114-146) (the "Cures Act") was instrumental to prevent EHR vendors from blocking the transmission of clinical outcomes data to third parties, such as QCDRs.

While we understand that the OIG and Office of the National Coordinator for Health Information Technology ("ONC") are developing rulemaking to implement such information blocking requirements, some EHR vendors are creating barriers to access patient information within their systems. For example, some EHR vendors require providers to pay a large annual fee to send their data from the EHR to the clinical data registry or their software vendor, or require purchasing intermediary software systems owned by the EHR. Cost-prohibitive interoperability deters physician participation in QCDRs. EHRs also refuse to provide full measure calculations to clinical data registries and only provide partial data on various measures. Much of this is also due to various EHRs having a stake in their own MIPS reporting modules, which provide incentives to their bottom line. Such barriers interfere with and materially discourage access to such information by clinical data registries. These obstructive tactics also create inefficiencies for physicians to report their data for MIPS. We look forward to working with the OIG and ONC to address these data blocking concerns to unlock QCDRs' potential to develop meaningful measures for the QPP.

Administrative Burden

MACRA also has increased physician burden through complex scoring and reporting requirements. Though much has been done to reduce reporting burdens on physicians who participate in MACRA, there is still more to do to ensure our health care system is able to address the needs of a growing and diversifying patient population. We believe QCDRs hold the key for data-driven policy changes and streamlined physician reporting, and would like to collaborate with you in strengthening the reliance on QCDRs as part of the Quality Payment Program. We are pleased that CMS has indicated further reduction in physician reporting will come through increased credit for the use of QCDRs. We encourage you to further strengthen QCDRs by ensuring that participation in QCDR reporting is sufficient for meeting threshold status for MIPS providers. This would reduce overall administrative burden on physicians and provide one outlet for them to report all of their measures through MIPS. We are pleased that many of the physicians we represent were able to avoid the penalty for MIPS in 2017 by reporting through a QCDR, with a significant percentage of them being recognized as high performers due to their having reported additional measures. This score adjustment would stimulate increased participation in QCDRs and accelerate QCDRs' development of quality measures that are relevant and meaningful to practicing physicians and their patients. Additionally, this could encourage EHR vendors to more readily share patient data, since MIPS credit is a significant selling point for EHRs.

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Again, the Academy appreciates the Subcommittee holding this hearing today, and the Academy appreciates the Subcommittee's efforts to address the clinician burdens in implementation of this important payment system changes under MACRA. Please feel free to contact Christine O'Connor, the Academy's Associate Director, Congressional Policy, at coconnor@aad.org or (202) 609-6330 if you have any questions or if we can provide additional information.



July 26, 2018

The Honorable Michael Burgess, MD
Chair, House Committee on Energy and
Commerce
Health Subcommittee
U.S. House of Representatives
Washington, DC 20515

The Honorable Gene Green
Ranking Member, House Committee on
Energy and Commerce
Health Subcommittee
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Burgess and Ranking Member Green:

On behalf of the American Academy of Family Physicians (AAFP) and the 131,400 family physicians and medical student members we represent, I write to express our continued support for the goals and objectives established by the *Medicare Access and CHIP Reauthorization Act (MACRA)*. We appreciate your efforts to evaluate the law and its implementation and thank you for seeking physician input as part of the Committee's hearing titled, "MACRA and MIPS: An Update on the Merit-based Incentive Payment System."

While the AAFP continues to support the underlying goals of the law, we do have concerns with the implementation of MACRA. As you know, MACRA placed a priority on the transition of physician practices from the legacy fee-for-service payment model towards alternative payment models (APM) that promote improved quality and efficiency. To date, the number of available APMs is not sufficient to achieve this goal. The AAFP has been actively engaged on the development of primary care focused APMs and is eager to work with the Centers for Medicare and Medicaid Services (CMS) and the Centers for Medicare and Medicaid Innovation (CMMI) to test these models. While we have concerns, we are encouraged by the new leadership at CMMI and the focus of their work.

Regarding the Merit-based Incentive Payment System (MIPS), we are concerned with the continued complexity of the scoring methodology, lack of timely and clinically actionable feedback, and terminology changes made by the agency. We recognize the administration's efforts to address this issue through proposals for 2019 and look forward to providing substantive feedback on those proposals and the new physician fee schedule's documentation guidelines.

To improve the Quality Payment Program (QPP), the AAFP advocates for the following policies:

- An opt-in pathway for those MIPS-eligible clinicians who find themselves below the low-volume threshold, which the agency proposes to add in 2019.
- Retention of cross-cutting measures in specialty sets with fewer than six measures to ensure parity in quality reporting across all eligible clinicians.
- New ways to hold harmless, for purposes of the cost category, physicians who cannot be reliably measured against at least one episode-based cost measure, until such time when CMS can create a more even and meaningful playing field for cost measurement.
- Decreased complexity of scoring in MIPS performance categories.

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- Support for the Physician-Focused Payment Model Technical Advisory Committee's role in evaluating physician-focused payment models (PFPs). We see significant value in broadening the PFP definition to include any public and private payment model.

For the past two decades, the AAFP has been a leading voice for reforms that move our delivery and payment systems away from the episodic, fee-for-service regime that has defined our health care system for much of the past 60 years. While fee-for-service will always have a role, we are convinced that it is, in most instances, not congruent with the delivery of patient-centered, comprehensive, and continuous advanced primary care.

Again, we appreciate the opportunity to offer our thoughts on this important issue and help set a specific, measurable, achievable, relevant, and time-bound goal to reduce administrative burden and focus on patients over paperwork. The AAFP stands ready to assist in achieving this important goal. For more information, please contact Sonya Clay, Government Relations Representative, at 202-232-9033 or sclay@aafp.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'John Meigs, Jr.', with a stylized flourish at the end.

John Meigs, Jr., MD, FFAFP
Board Chair

**Statement for the Record****American College of Physicians****Hearing before the Energy and Commerce Health Subcommittee****On****MACRA and MIPS: An Update on the Merit-based Incentive Payment System****July 26, 2018**

The American College of Physicians (ACP) is pleased to submit this statement for the record and appreciates the efforts of Chairman Burgess and Ranking Member Green in convening this hearing on the Merit-based Incentive Payment System (MIPS). Thank you for your shared commitment in wanting to ensure that the payment and delivery system reforms created under the Medicare Access and CHIP Reauthorization Act (MACRA) are implemented successfully and as intended by Congress. We also appreciate the subcommittee and full committee inviting input from the physician community throughout the implementation process, and for your continued oversight of the Quality Payment Program (QPP). We wish to assist in these efforts by offering our input and suggestions on the ongoing implementation of MIPS, as noted in detail below.

ACP is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 154,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

OVERVIEW OF ACP's VIEWS ON MACRA

To reiterate what ACP has stated in its many communications to Congress on MACRA and the QPP, the College has been a strong supporter of MACRA and embraces its goal of creating

incentives for physicians and other clinicians to improve quality and to adopt alternative payment models (APMs) aligned with the result in better value for patients and the program. MACRA remains a major improvement over the preceding fee-for-service (FFS) system with yearly adjustments based on Medicare's Sustainable Growth Rate (SGR) formula, to one of value, accountability, and patient-centered care. However, continued improvements are needed for the QPP, as created by MACRA, to fully deliver on its intent.

The College has been active in providing feedback on the QPP via its comment letters to the Centers for Medicare and Medicaid Services (CMS) on both the 2017 and 2018 final rules, the Center for Medicare and Medicaid Innovation's (CMMI's) request for information on a "new direction," and the Measure Development Plan, as well as numerous other requests for information and feedback from the Agency.

The Merit-based Incentive Payment System (MIPS)

The College believes that MIPS plays an important and essential role in offering a pathway for physicians who continue to be reimbursed under the traditional Medicare FFS system to make changes in their practices to improve the value of care provided to patients as a step toward participating in more transformative APMs. That said, despite important steps being taken by the current and previous administrations to make MIPS as effective as possible, many ACP members remain concerned that reporting on many of the measures used by MIPS is overly burdensome, measures the wrong things, and is not likely to bring about real improvements in outcomes. Indeed, ACP's Performance Measurement Committee has reviewed many of the measures currently being used by MIPS and has determined that they lack validity, or are of uncertain validity. Other aspects of MIPS could also be simplified and improved. ACP specifically believes MIPS could be more effective if the following changes were made:

1. Simplify MIPS

Congress envisioned MIPS as a solution to the discounted and siloed legacy programs of the past. MIPS was designed to be a single, consolidated, and streamlined federal quality reporting program that aligned reporting objectives and measures into straight-forward requirements

that minimize burden on clinicians and practices. Unfortunately, certain aspects of MIPS' original design have led to unexpected challenges, resulting in ongoing complexity and little improvement in the harmonization of reporting requirements. Therefore, the College appreciates that Congress recognized the need for CMS to have additional flexibilities in certain areas to allow for a number of improvements and updates via several technical changes in the Bipartisan Budget Act of 2018 (H.R. 1892). This law enabled CMS to adjust the weighting of the Cost Performance category and make important changes to the methodology for establishing the performance threshold.

ACP offered the following additional suggestions to further simplify the program:

- CMS must simplify the overall scoring approach so that the point value for each measure or activity reflects its relative value within the composite performance score (CPS). For example, the points within the Quality component would total 50 points, which reflects the current weight of that category.
- CMS should remove the weighting of individual Improvement Activities, as it adds unnecessary complexity and it is unclear what evidence might indicate why certain activities might be considered "medium" versus "highly" weighted.
- The Promoting Interoperability category of the program should be even further simplified. Currently, clinicians must contend with a scoring methodology that divides the category into three separate components, each scored a different way, that add up to a total of 155 points, while the category is actually scored out of 100 points. Of note, in the recently released notice of proposed rulemaking with changes to the QPP for the 2019 performance year, CMS does propose to "overhaul" scoring for this category, including getting rid of the separate "base" and "performance" scores, evaluating all measures on the same performance basis, and creating alignment between MIPS and other Medicare programs. ACP is encouraged by these proposals and will be reviewing them closely in order to provide feedback to the Agency.

2. Increase support for small practices and those in rural and underserved areas

Small practices and those in rural and underserved areas are repeatedly outperformed by their larger and more integrated counterparts on MIPS metrics. Often however, this is more a reflection of their lack of resources and ability to strategize than a true reflection of their value of care. To help address these concerns, we offer the following recommendations:

- Support CMS' recent proposal in the 2019 QPP rule to allow clinicians who would otherwise qualify for exemption from MIPS under the low-volume threshold, the option to "opt in" to MIPS. This would increase participation in the program without imposing additional undue burden on physicians and is strongly supported by the ACP.
- Increase assistance specifically geared to small practices, including possibly financial assistance for purchasing technologies such as Electronic Health Record (EHR) systems or registries, which can be instrumental in leveraging access to real-time data to drive high-value care, but can often be prohibitively expensive, particularly for small and rural practices. Even for practices that already have implemented an EHR and/or other technology solutions, there are significant costs associated with paying for the necessary upgrades due to the annual changes in the MIPS program requirements.
- Urge CMS to extend the small practice bonus to clinicians in rural and underserved areas.
- Urge CMS to establish a separate, lower nominal risk amount standard for small and rural APM entities, such as one that aligns with the medical home model nominal risk standard. This will allow practices that do not have the same sophistication of infrastructure or liquid financial resources as larger practices the opportunity to participate in innovative APMs to improve care and reduce costs for their patient populations.

3. Reduce administrative burden

Physician practices spend \$15.4 billion per year, or approximately \$40,000 per physician, to report on performance. In addition to costing practices financial resources and hours of staff time, the administrative burden created by MIPS and other federal programs is a leading contributor to physician burnout. ACP has made reducing the burdens of regulatory and administrative tasks one of our top advocacy priorities, as evidenced in the launch of our Patients before Paperwork initiative in 2015. We strongly support CMS' "Meaningful Measures"

and “Patients over Paperwork” initiatives but believe there is more opportunity for improvement in this area. Congress can help to support these important, ongoing efforts to reduce administrative burden in the following ways:

- Urge CMS to award cross-category credit, where one high priority activity or measure could earn points in multiple performance categories. This would allow practices to focus in on meaningfully driving improvement in key strategy priority areas. For instance, practices could report through their EHR system that they began participating in a prescription drug monitoring program, which could potentially earn that practice points in the Improvement Activities, Quality, and Promoting Interoperability categories while helping to combat the nation’s opioid epidemic.
- Urge CMS to reduce the minimum quality reporting period from a full year to 90 consecutive days to align with the Promoting Interoperability and Improvement Activities categories. This will have an immediate impact on reporting burden, will create consistency across the performance categories, and will allow for much-needed flexibility. Should practices experience any difficulties throughout the reporting year, such as technical malfunctions by their EHR product, which are reported commonly by our members, rather than claiming a hardship exception for an entire performance year, the practice would simply report on another 90-day window unaffected by the technical glitch.
- Urge CMS to move the performance period closer to the payment adjustment year as soon as possible. As it stands currently, clinicians receive performance feedback six months after the performance year has concluded. Payments are impacted two years later. Such a delayed cycle can hardly be considered to drive quality and generates mass confusion because reporting requirements and scoring rules change year-to-year. Shortening the reporting, feedback and payment cycle will allow clinicians to receive more timely feedback so that they can truly leverage that information to drive improvement in their practices, rather than simply engaging in a reporting exercise after the fact. Ideally, CMS would provide access to real-time Medicare claims data.
- Urge CMS to allow for an appropriate amount of time for practices to transition to new 2015 Edition CEHRT. The College supports the transition to the new 2015 Edition Certified

EHR Technology (CEHRT) to place greater emphasis on improved interoperability between EHR systems. However, upgrading this technology takes time and comes at a significant expense to practices. It cannot occur overnight. It will take time for vendors to reconfigure the systems to accommodate the new standards, as well as for practices to train clinical and administrative staff on the new requirements and system functionalities. Allowing only a few months between the release of the final rule and the proposed implementation date of Jan. 1, 2019 is likely to result in widespread software glitches that could pose risks to patients' health. The College recommends a minimum of six months for vendors and practices to perform the necessary system upgrades and staff training to ensure a smooth transition on such a massive scale.

- Under the Promoting Interoperability category, CMS currently scores certain measures on an "all-or-nothing" basis, where clinicians must report on all required measures or be given a score of zero for the entire performance category. In the recently proposed rule with changes to the QPP for the 2019 performance year, CMS proposes to overhaul the scoring methodology for the Promoting Interoperability category, as noted previously. However, the proposals technically expand the number of required measures that, if not reported, would lead to a total score of zero in this category. ACP has expressed serious concerns about this approach in the past and the burden it imposes on physician practices that could report the vast majority of measures, but may struggle with a single measure for any number of reasons, including relevant patient population, EHR functionalities, etc. One of the improvements that Congress had the foresight to make to the QPP under MACRA compared to the legacy programs was to stop using this cliff-based scoring approach under which a clinician could fulfill the majority of requirements but be awarded zero credit for failing to report a single measure. Instead, MACRA specifically calls on CMS to implement a "sliding scale" scoring approach that rewards clinicians proportionally for the amount of data they report. We urge Congress to use its oversight authority to impress upon CMS that this all-or-nothing scoring approach that continues to be used for the Promoting Interoperability category conflicts with Congressional intent under MACRA and subjects practices to undue administrative burden and financial risk, given the substantial expense of EHR systems.

- We understand the need to collect meaningful data, but only in the case where it is pulled from the EHR without additional steps required by the physician.

4. Improve the accuracy of MIPS measures and data

Nearly two thirds of practices reported that the current measures do not accurately capture the quality of care they provide. ACP has strongly advocated for CMS and other payers to ensure that reported measures are evidence-based, outcomes-focused, and aligned within the existing clinical workflow, and that they undergo a multi-stakeholder evaluation process. We offer the following specific recommendations to further refine and improve the accuracy of MIPS data:

- Urge CMS to collaborate in a multi-stakeholder evaluation process to develop, test and implement both new and existing measures to create a streamlined set of evidence-based, outcomes-focused quality measures that align within existing clinical workflows, thereby minimizing clinician burden. This not only includes filling critical measure gaps, but also removing measures that are poor quality as needed. Our Performance Measurement Committee conducted an in-depth scientific review of the validity of 86 QPP quality measures relevant to ambulatory general internal medicine and found that just one third were valid (35 percent were not valid and 28 percent were of uncertain validity). We urge Congress and the administration to look to these recommendations first when considering internal medicine measures. Next, Congress and the administration should look to measures endorsed by the Core Measures Collaborative and recommended by the Measure Application Partnership. Of note, in the proposed 2019 QPP rule, CMS proposes to retire 34 and add 10 new quality measures. While ACP is still closely analyzing the impact of these proposed measure additions and removals, we are encouraged that CMS is taking steps to remove what it considers to be low-value measures. However, we underscore the importance of taking concrete actions to ensure specialty clinicians have a sufficient number of measures to report so that they can successfully participate in the program.
- Urge CMS not to increase the weight of the Cost category in the same year that new measures are being introduced. ACP appreciates that Congress added an additional three years of flexibility in setting the weight of the Cost (formerly Resource Use) Performance

category in Sec. 51003 of the Bipartisan Budget Act of 2018 (H.R. 1892), which will provide much-needed time for CMS to continue developing and refining new episode groups, patient relationship categories, and patient condition categories. However, next year, CMS proposes to introduce eight new episode-based cost measures while simultaneously increasing the weight of the Cost category from 10 percent to 15 percent. The Cost category should not increase above its current weight of 10 percent until CMS is able to fully evaluate the reliability and accuracy of these new measures.

- Urge CMS to address current flaws in risk adjustment methodologies that fail to accurately account for socioeconomic status, which create a system that inappropriately penalizes physicians with higher numbers of lower income or frailer patients. It is vitally important that MIPS help to reduce, rather than exacerbate, current disparities in care due to social inequities. Properly controlling for socioeconomic factors is critical to both learning more about these populations and understanding ways to help reduce this gap, and ensuring clinicians are not adversely penalized for caring for at-risk or more complex patient populations, which could result in access issues for vulnerable patients.
- Urge CMS to address flawed patient attribution methodologies for the total per-capita cost and Medicare Spending per Beneficiary (MSPB) measures, which were carried over from the Value-Based Payment Modifier legacy program and inappropriately attribute broad-based costs to physicians for services that are outside of their control and that they do not have the ability to impact, such as costs associated with care settings outside of the physician's practice.
- Encourage CMS to allow practices to subdivide into smaller groupings (i.e., specialties, practice sites, etc.) for performance assessment purposes to allow for selection of performance measures and activities that are most relevant to a clinician's scope of practice and patient population.

ACP TOOLS AND RESOURCES ON MACRA

ACP wants to give internists and subspecialists the best chance possible to succeed in the QPP, be it through the MIPS or APM pathway. To that end, ACP has developed tools and resources

for its members to help them navigate through the QPP; chief among them is the Quality Payment Advisor®.

Quality Payment Advisor®

The Quality Payment Advisor® is an educational tool that is intuitive to the needs of clinicians participating in the QPP. This tool provides a systematic approach to succeed in the QPP by helping to determine who is eligible for the QPP, which reporting pathway is best, as well as assistance with quality measure/activity selection and implementation. Each question offers information and resources to guide the user through the algorithm toward understanding which pathway is most appropriate for their practice. The modules provide guidance and resources to select and implement measures and activities. It should be noted that this tool cannot help with all measures or activities but to the extent possible the ACP hopes that it proves to be useful in implementing quality measures and activities most commonly applicable to internal medicine and sub-specialty practices.

Top Ten Ways to Succeed under the QPP

In addition, ACP has created a host of resources on the QPP, including a Top Ten list of things that clinicians should be doing to be successful under the QPP. This list provides ACP members with a roadmap to understanding and complying with all the demands and opportunities within the MIPS and APM pathways.

Conclusion

ACP greatly appreciates the subcommittee convening this hearing and for its continued desire to see that the value-based system, as established under MACRA, is successfully implemented. We very much want to be part of this process as implementation continues and to provide feedback whenever needed. Please contact Jonni McCrann at jmccrann@acponline.org with any questions or if additional information is needed.



July 25, 2018

The Honorable Michael Burgess, MD
Chairman
Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives
Washington, District of Columbia 20515

The Honorable Gene Green
Ranking Member
Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives
Washington, District of Columbia 20515

Dear Chairman Burgess and Ranking Member Green,

We applaud this Subcommittee for reviewing the progress of the Center for Medicare and Medicaid Services (CMS) as it works to implement the Medicare Access and CHIP Reauthorization Act (MACRA). We share Congress' overarching goal to move the Medicare system from a largely fee-for-service model to one that rewards the value and cost-effectiveness of healthcare. We note that MACRA is driving these changes, including through the implementation of telehealth and remote monitoring technologies.¹

The Connected Health Initiative (CHI) represents a broad consensus of stakeholders in the connected health sector. As part of ACT | The App Association, CHI represents a large community of small app developers and connected device companies that create the innovations that improve the lives and health of patients across America. We offer several observations and recommendations as the Subcommittee considers the next step for value-based care and the role of technology-driven tools in advancing this goal.

CHI urges this Subcommittee to recognize the strong evidence base that demonstrates the efficacy and cost savings associated with the use of cutting-edge remote monitoring tools. Several studies have shown that providing remote care results in fewer hospitalizations, cost savings, and improved health outcomes. For example, a randomized control trial of telehealth and telecare services concluded that, "if used correctly telehealth can deliver a 15 percent reduction in A&E visits, a 20 percent reduction in emergency

¹ E.g., 42 U.S.C. 1395w-4(q)(2)(B)(iii)(III) (requiring CMS, for care coordination, to ensure the use of remote monitoring or telehealth).

admissions, a 14 percent reduction in elective admissions, a 14 percent reduction in bed days and an 8 percent reduction in tariff costs. More strikingly they also demonstrate a 45 percent reduction in mortality rates.”² One of the most promising applications for remote monitoring is for patients with chronic conditions. A University of Ottawa Heart Institute study supports this proposition, finding that “telehome monitoring” cut hospital readmission for heart failure by 54 percent, and secured savings up to \$20,000.³

Nowhere are the potential benefits of connected care more pronounced than in rural America. In a pioneering diabetes self-management study, CHI steering committee member University of Mississippi Medical Center (UMMC) found that the program’s first 100 patients saved an impressive \$339,184 in healthcare costs by using remote monitoring and telehealth tools. Cost analyses predict that if 20 percent of Mississippi’s diabetic population was enrolled in the program, it would bring \$189 million in Medicaid savings to Mississippi each year.⁴

Under this Subcommittee’s guidance, CMS has already taken important steps to incorporate connected health tools that save lives and reduce costs. Specifically, the Physician Fee Schedule (PFS) rulemaking introduced unbundled current procedural terminology (CPT) code 99091 to support the use of remote monitoring tech. As the Medicare system makes strides to move past its legacy of fee-for-service payment, CMS has also been shaping its Quality Payment Program (QPP), pursuant to MACRA provisions. As part of the QPP’s merit-based incentive payment system (MIPS) rules rolled out last year, CMS adopted an Improvement Activity (IA) proposed by CHI—IA_BE_14 : Engage Patients and Families to Guide Improvement in the System of Care—which incents providers to leverage digital tools for patient care and assessment outside the four walls of the doctor’s office. The IA urges providers to ensure that any devices they use to collect patient-generated health data (PGHD) do so as part of an active feedback loop. CHI is especially encouraged that CMS assigned high weight and linkage to an Advancing Care Information (ACI) bonus to this IA, which signals to healthcare providers that CMS acknowledges the important role connected health tools can play in improving health outcomes and controlling costs. We commend CMS for taking these and steps in support of connected health solutions that will improve the care of every Medicare beneficiary while reducing program costs. We urge this Subcommittee to ensure CMS continues in this direction.

While good progress has been made, it is important that this Subcommittee recognize that much work remains to be done to realize MACRA’s vision of a value-based Medicare system. With CMS currently contemplating its next steps as far as needed changes to

² “Whole System Demonstrator Programme, Headline Findings – December 2011,” Department of Health, United Kingdom, *available at* <https://www.gov.uk/government/publications/whole-system-demonstrator-programme-headline-findings-december-2011>.

³ University of Ottawa Heart Institute, Feb. 24, 2011, Press Release, *available at* <https://www.heartandlung.org/article/S0147-9563%2807%2900084-2/fulltext>.

⁴ http://www.connectwithcare.org/wp-content/uploads/2017/06/2016_Outcomes_Clinical-1.pdf.

both the PFS and QPP, this Subcommittee's hearing is taking place at a crucial time. There are several encouraging proposals in the draft calendar year (CY) 2019 PFS/QPP that this Subcommittee should ensure CMS adopts, such as CMS' proposal to activate three additional remote monitoring codes. CHI contributed to the development of these codes, which if adopted, will support the use of remote monitoring innovations in the Medicare program. Further, CMS is considering additional changes to the MIPS program to give due credit for using connected health technology innovations in care delivery when calculating a MIPS score. Such proposals should move forward, incorporating the thoughtful feedback of the connected health stakeholder community. Other areas, like Alternative Payment Models (APMs) under the QPP, merit greater attention from by CMS so that a clear message is sent to all stakeholders that remote monitoring tools should serve a key role in the success of future innovative APMs. CHI continues to examine CMS' proposed rule to identify additional opportunities to realize Congress' vision of a value-based Medicare system. We commit to continue to assist this Subcommittee in this respect.

We appreciate the Subcommittee's continued focus to ensure that CMS carries out its statutory mandate under MACRA. With your oversight, we believe CMS can stay on track to bring Medicare into the 21st century to ensure health providers have the tools they need to succeed and better serve patients.

Sincerely,



Graham Dufault
Connected Health Initiative



Brian Scarpelli
Connected Health Initiative



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July 26, 2018

The Honorable Greg Walden
Chairman
Energy & Commerce Committee
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Washington, DC 20515

The Honorable Michael Burgess, MD
Chairman
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Subcommittee on Health
U.S. House of Representatives
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The Honorable Frank Pallone
Ranking Member
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The Honorable Gene Green
Ranking Member
Energy & Commerce
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U.S. House of Representatives
Washington, DC 20515

Dear Chairman Walden and Ranking Member Pallone, Chairman Burgess and Ranking Member Green,

The American Society of Clinical Oncology (ASCO) is pleased to submit this statement in relation to the hearing, "MACRA and MIPS: An Update on the Merit-based Incentive Payment System." ASCO supported the passage of MACRA as a replacement to the flawed Sustainable Growth Rate and we applaud this committee for your shared commitment to its success.

ASCO continues to educate its members on how to make MACRA work for their practices and the Medicare beneficiaries they serve. Practice tools and webinar resources are readily available on asco.org/MACRA, and in July 2017, ASCO updated its Quality Oncology Practice Initiative Quality Clinical Data Registry (QOPI® QCDR) to allow practices to seamlessly report MIPS data via electronic medical record data.

Further, we thank the committee for its leadership in the passage of critical technical fixes to the legislation passed in February of this year. Specifically, we appreciate the inclusion of language to remove Part B drugs from the low volume threshold and scoring adjustments in MIPS and the additional flexibilities in the cost category provided to CMS.

Making a world of difference in cancer care

The recently released 2019 Quality Payment Program (QPP) rule in combination with the Medicare Physician Fee Schedule (MPFS) raises several questions about how oncology practices will be able to continue to provide the highest quality care for Medicare beneficiaries. The QPP rule proposes an increase in weight for the cost category from 10% to 15% but lacks an updated methodology, including risk adjustment for the severity and variation of high cost therapies and potential hospitalization at times necessary to treat cancer patients.

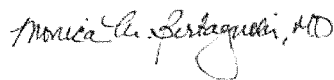
Additionally, the MPFS proposes a 4% overall cut in reimbursement for oncology services, a decrease in reimbursement for new Part B drugs, and an overhaul of evaluation and management (E&M) coding that does not reflect accurately services and resources practices deliver to complex patients. To offset the reduction in reimbursement, oncology practices may be forced to reduce unpaid or underpaid but important services currently provided to patients with cancer. ASCO opposes the cuts in the proposed MPFS and believes they will harm Medicare beneficiaries with cancer, impede MIPS implementation, and risk access to appropriate anti-cancer therapies.

The proposed MPFS reimbursement cuts would diminish the reward to high performing providers Congress intended under MACRA in this first year the MIPS adjustments will be applied. Coupled with the MPFS, the best performers would only receive a 2% bonus. This is much lower than the 4% authorized by law. Providers and practices meeting all the necessary quality improvement/value requirements will still have an overall decrease in reimbursement for the 2019 year.

Over the coming months, ASCO will be in touch with the Center for Medicare and Medicaid Services (CMS) as well as this Committee about the impact of these proposals on cancer care.

ASCO thanks the Committee for its commitment to improving the Medicare program. If you have questions about this or any issue affecting cancer care, feel free to reach out to Amanda Schwartz at amanda.schwartz@asco.org or 571-483-1647.

Sincerely,

A handwritten signature in black ink that reads "Monica M. Bertagnolli, MD". The signature is fluid and cursive, with the first name "Monica" and last name "Bertagnolli" clearly legible, followed by "MD".

Monica M. Bertagnolli, MD, FACS, FASCO
President, American Society of Clinical Oncology



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IDS

Infectious Diseases Society of America

July 25, 2018

The Honorable Michael Burgess, MD
Chairman
Subcommittee on Health Committee on Energy & Commerce
United States House of Representatives
2336 Rayburn House Office Building
Washington, DC 20515

The Honorable Gene Green
Ranking Member
Subcommittee on Health Committee on Energy & Commerce
United States House of Representatives
2470 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Burgess and Ranking Member Green,

The Infectious Diseases Society of America thanks you for scheduling the hearing, "MACRA and MIPS: An Update on the Merit-Based Incentive Payment System." IDSA represents more than 11,000 infectious diseases (ID) physicians and scientists devoted to patient care, prevention, public health, education, and research in infectious diseases. Our members care for patients with serious infections, including HIV/AIDS, viral hepatitis, healthcare-associated infections, antibiotic-resistant infections, as well as emerging infections such as the Middle East Respiratory Syndrome coronavirus (MERS-CoV), Ebola virus and Zika virus diseases. IDSA provided [detailed comments](#) to the Centers for Medicare and Medicaid Services on the 2018 final rule of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Programs, collectively known as the Quality Payment Program (QPP).

Outlined below, we are pleased to describe the important roles of ID physicians. Please note several provisions of the 2018 final rule that we support. We also strongly recommend important changes to MIPS related to antibiotic resistance and antibiotic stewardship and highlight an underlying ID physician compensation issue that is hampering our ability to meaningfully participate in new payment models and indeed may threaten the future of our subspecialty.

The Value of ID Physicians

IDSA members are committed to improving the quality and the safety of patient care in hospitals and health systems across the nation. Many lead the "on-the-ground" efforts to address healthcare-associated infections, antimicrobial resistance, and bio-emergencies. The specialty of infectious diseases is unique in that it is the only specialty that routinely emphasizes the linkage between individual patient care and the impact on the larger patient population. 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. ID physicians care for some of the most complex patients and are essential to the safety and effectiveness of many life-saving medical interventions, including organ and bone marrow transplants, complex surgeries and cancer chemotherapy. ID physicians also conduct research leading to breakthroughs in the origin and transmission of emerging and re-emerging diseases, factors that make these diseases virulent, and the development of urgently needed new antimicrobial drugs and other therapies, diagnostics, and vaccines.

2018 final rule of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Programs, collectively known as the Quality Payment Program (QPP)

IDSA appreciates that the 2018 final rule of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Programs, collectively known as the Quality Payment Program (QPP) included many improvements and recommendations we made in response to the proposed rule. We also reiterate some concerns and recommendations below.

- IDSA appreciates that the final rule includes the facility-based measurement option as a proxy for MIPS quality and cost measurement for facility-based physicians. We remain concerned that many ID physicians who are facility-based will have difficulty participating in MIPS in a meaningful way until the facility-based scoring is finalized.
- IDSA is pleased that the final rule includes a five-point complex patient bonus (as ID physicians often treat the “sickest of the sick” on a regular basis) and includes a small practice bonus.
- IDSA supports the final low volume threshold of \$90,000 in Part B-allowed charges and 200 Medicare Part B beneficiaries, which we believe will lower administrative burden, particularly for small practices and practices in rural and underserved areas, allowing them to focus their limited resources on patient care.
- IDSA supports the finalized options for the implementation of virtual groups for participation in MIPS, but we await further details as to how virtual groups will be constructed. If CMS is committed to relieving administrative burden, then we believe CMS should assist physicians in forming their virtual groups.
- IDSA appreciates the CMS decision not to finalize the requirement for eligible clinicians to report cross-cutting measures. We encourage CMS to remove the requirement entirely, as it would intensify administrative burden and increase the likelihood that our members would not be able to report to MIPS satisfactorily.
- IDSA appreciates the inclusion of an infectious disease specialty measure set for MIPS. Nonetheless, we continue to have strong reservations regarding the clinical relevance of the majority of the measures to the practice scope for many ID physicians. Of the proposed measures, IDSA recommends that only those that align with the practice of an ID physician be included. Specifically, we support the inclusion of measures regarding influenza immunization, pneumococcal vaccination, documentation of current medications, and appropriate treatment of Methicillin-Sensitive *Staphylococcus Aureus* (MSSA) bacteremia.
- Recognizing that there are significant financial incentives participation in an Alternative Payment Model (APMs), we call attention to the challenges that exist for ID physician participation. Unlike procedure-based care, ID and other cognitive care typically does not

have easily identifiable episodes of care that result in easily measured patient outcomes. Even when there is an easily identifiable episode of care, (i.e. patient with cellulitis within the Bundled Payment Care Improvement – Advanced Program), the program design has made it impossible for ID physicians to design a value-based care plan for the episode, (i.e. the BPCI-Advanced program required that a patient with cellulitis be admitted to the hospital to “trigger” the episode). ID physicians would like to be able to demonstrate their value by designing episode bundles that avoid having a patient admitted to the hospital.

Improvement Activities: Implementation of an Antibiotic Stewardship Program

IDSA would like to highlight for the Subcommittee the improvement activity entitled “Implementation of an Antibiotic Stewardship Program (ASP),” for three key reasons: First, we greatly appreciate this subcommittee’s strong attention to the national and global crisis of antibiotic resistance and the subcommittee’s leadership in driving solutions. Second, we believe this component of MIPS represents a key area where ID physicians will be particularly able to participate in a meaningful way. Third, we believe changes to CMS policy are necessary to maximize the impact of this component of MIPS.

IDSA believes that the listed example conditions in this improvement activity (IA) should either be removed entirely or revised to note that antibiotic stewardship applies to any infectious disease condition, and not just those listed in the improvement activity. We remain concerned that the listed conditions may be interpreted as the only conditions for which this improvement activity is applicable, therefore making this improvement activity overly prescriptive and subject to misinterpretation.

High Weight for implementation of an Antimicrobial Stewardship Program

We continue to urge the Agency to make the Implementation of an ASP a high weighted improvement activity. IDSA believes that implementation of an ASP would meet the parameters set by the Agency when determining if an IA should be of high weight. In the QPP Final Rule for 2017, CMS stated, “we believe that high weighting should be used for activities that directly address areas with the greatest impact on beneficiary care, safety, health, and well-being.” Antibiotic stewardship directly provides an impact on beneficiary care, safety, health, and well-being by assisting providers and facilities in prescribing the correct antibiotic, using the correct dose, and for the correct amount of time. Antibiotic stewardship programs have been demonstrated to reduce inappropriate antibiotic use that drives the development of resistance and to reduce adverse events associated with antibiotic use, such as *C. difficile* infection.

Finally, as this Subcommittee is well aware, antibiotic stewardship programs play a central role in combating antibiotic resistance nationally and globally. Expert national and international bodies including CMS, the Centers for Disease Control and Prevention, the National Institutes of Health, the Food and Drug Administration, the President’s Council of Advisors on Science and Technology and the World Health Organization have all emphasized ASP as a priority recommendation. Given the societal and population health impact of using antibiotics appropriately, the work involved in the implementation of an ASP, and the work involved in continually supporting and administering an ASP, we believe that this should be a high weighted IA.

Undervaluing ID: Jeopardizing the Next Generation of ID Physicians

We want to highlight for the Subcommittee that MACRA implementation is occurring against a complex backdrop 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 21.6% decline in the number of applicants to infectious disease fellowship training programs over a 5-year period ending in 2016. These data indicate a broader problem—the undervaluation of ID.

In 2014, an IDSA survey of nearly 600 Internal Medicine residents revealed that 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. 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 current payment systems compared to procedural patient encounters (e.g., surgery, cardiology, and gastroenterology), as current E/M codes fail to reflect the increasing complexity of E/M services. This accounts for the significant compensation disparity between ID physicians and physicians that provide a greater proportion of procedure-based care.

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 patient care 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. ID care often involves reviewing ill patients with many days of hospitalization or complex outpatient case management that are both time intensive to do well. 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 Subcommittee 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.

Reimbursement for Telemedicine

ID physicians are increasingly seeking opportunities to utilize telemedicine to expand access to care, particularly in rural and other underserved communities, and to conduct clinical research and provide continuing medical education. The Extension for Community Health Outcomes (ECHO) program has demonstrated success in treatment of hepatitis C virus. Evidence also supports the use of telemedicine for HIV management, for which subspecialty care can be critical. Compared to in-person management by generalists, subspecialty care using telemedicine has been shown to improve virologic suppression and result in a greater rise in CD4+ T-cell counts in a large prison population and may prove beneficial for HIV care in other resource-limited settings. Telemedicine can also be used to expand ID physician-led services, including antibiotic stewardship programs and infection prevention and control programs, to a wide variety of healthcare settings. We appreciate this Subcommittee's ongoing attention to telemedicine and encourage additional efforts to promote use of telemedicine to allow reimbursement for care delivered remotely.

PAGE 5—IDSA Comments to E&C Subcommittee on Health Re MACRA and MIPS

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

Sincerely,

A handwritten signature in black ink, appearing to read "Paul Auwaerter", with a stylized flourish extending to the right.

Paul G. Auwaerter, MD, MBA, FIDSA
President, IDSA



Medical Group Management Association

Statement for the record

**Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives**

**Re: MACRA and MIPS: An Update on the Merit-based
Incentive Payment System**

**Anders Gilberg, MGA
Senior Vice President, Government Affairs
agilberg@mgma.org**

**1717 Pennsylvania Ave NW Suite 600
Washington, DC 20006
202.293.3450**

July 26, 2018

The Medical Group Management Association (MGMA) commends the Committee on Energy and Commerce Subcommittee on Health for convening this hearing on “MACRA and MIPS: An Update on the Merit-based Incentive Payment System.” MGMA represents 12,500 medical group practices of all sizes, specialties, types and structures, which collectively provide almost half of the healthcare in the United States.

MGMA appreciates the Committee’s ongoing leadership and oversight efforts to ensure successful implementation of the sweeping payment reforms enacted in the Medicare Access and CHIP Reauthorization Act (MACRA). We applaud Congress making technical corrections to MACRA in the Bipartisan Budget Act, which demonstrated your continued support for the innovative care delivery improvements taking place in group practices across the country. We are optimistic that these changes will be a catalyst for improving the Merit-based Incentive Payment System (MIPS) beginning in 2019 and expanding Advanced Alternative Payment Model (APM) opportunities in the near future.

Since MACRA passed, MGMA has partnered with Congress and the administration to help physician practices succeed in the Quality Payment Program (QPP). We have hosted numerous educational events that connect our members directly with Centers for Medicare & Medicaid Services (CMS) staff, served as informational and educational resources for our members by dispensing news and information related to MIPS, and provided suggestions to policy makers based on feedback from our members. We also collaborate with other stakeholder groups as part

of various coalitions, including a MIPS workgroup that submitted to CMS comprehensive suggestions for reducing clinician burden, several of which are reflected in these comments.

We appreciate Congress' work to support physician practices transitioning to value-based payment in Medicare by passing MACRA and exercising oversight authority to help facilitate implementation. We hope these comments will help Congress and the administration improve the QPP, align it with congressional intent in MACRA, and ensure a successful transition to a Medicare payment system centered around high-value care.

Reduce Medicare quality reporting documentation requirements

Repealing the problematic sustainable growth rate and retiring a hodgepodge of quality reporting programs, MACRA charted a value-based trajectory for the Medicare payment system by valuing innovative, patient-centric and efficient care delivery over check-the-box bureaucracy. However, the final 2018 MIPS rule maintains an overly complex set of rules that reward the quantity of reporting rather than the quality of care provided to patients. One of the most onerous requirements in MIPS is the mandatory 365-day data collection and reporting period.

CMS' own estimates show full-year quality measure tracking and reporting is estimated to cost medical groups close to \$700 million in 2018.¹ Based on a study of MGMA member practices, this cost estimate may be low. Our research determined that each year physician practices in four common specialties spend, on average, 785 hours per physician and more than \$15.4 billion on quality measure reporting programs.² Most of the time spent on quality reporting consists of "entering information into the medical record only for the purposes of reporting for quality measures from external entities."

We urge this Subcommittee to provide immediate relief by working with CMS to shorten the current MIPS quality reporting period to 90 consecutive days. There is precedent for this action. In response to the introduction of legislation to shorten the Meaningful Use EHR reporting period from a full year to three months, CMS retroactively amended its regulations to relieve the onerous reporting burden.³ Congress should consider using its influence in the same way to relieve the quality reporting burden in MIPS.

Put patients over paperwork in MIPS

MGMA strongly supports CMS' goal to emphasize "high-value care and patient outcomes while minimizing burden on eligible clinicians" in MIPS. Unfortunately, rather than relieve the burdens of participation, the current MIPS program exacerbates them. Rather than maintain a stable, already robust reporting period minimum of 90 days across all MIPS categories in year two, CMS quadrupled the reporting period for quality measures. Rather than realize the goal of MACRA to streamline quality reporting under one program, CMS continued the siloed approach

¹ 82 Fed. Reg. 53577, *Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year*, CMS-5522-FC and IFC.

² Lawrence P. Casalino, David Gans, Rachel Weber, Meagan Cea, Amber Tuchovsky, Tara F. Bishop, Yesenia Miranda, Brittany A. Frankel, Kristina B. Ziehl, Meghan M. Wong and Todd B. Evenson, "US Physician Practices Spend More Than \$15.4 Billion Annually to Report Quality Measures," *Health Affairs* 35, no.3 (2016).

³ H.R. 3940. The Meaningful Use Hardship Relief Act of 2015.

of PQRS, Meaningful Use, and the Value Modifier by drawing bright lines between the four MIPS categories, each of which has a unique, complex reporting and scoring scheme. Not only does this increase in regulatory burden contradict CMS' initiative to promote patients over paperwork, it coincides with growing skepticism that MIPS as implemented neither reflects nor incentivizes clinical quality improvements in medical groups. According to a recent study of more than 750 MGMA member practices, more than 70% of respondents were very or extremely concerned about the lack of clinical relevance to patient care.⁴ Articulating a theme we hear regularly across the country, one practice leader wrote: "We are a GI single specialty clinic. I can use the specialty measures for the MDs but not the mid-level providers as they don't apply. I have to have two sets of MIPS requirements and measures. It's extremely burdensome."

To assist CMS in resetting its approach and achieving its stated goals of reducing clinician burden in MIPS and enhancing patient care, MGMA encourages Congress to instruct CMS to make the following high-impact improvements to MIPS:

1. **Permanently shorten the minimum MIPS quality reporting period to any 90 consecutive days** using sampling and attestation methodologies that ensure statistical validity. Participants should have the option to report more data as needed.
2. **Decrease the number of measures across MIPS.** Physician group practices' finite resources are spread across at least 15 measures, including a minimum of six quality measures, two cost measures, five advancing care information (ACI) measures, and two improvement activities. CMS should structure MIPS to allow practices to prioritize effective and impactful improvements to patient care, rather than comply with sprawling reporting mandates.
3. **Simplify MIPS and reduce redundancies by awarding cross-category credit.** As implemented, MIPS reflects a continuation of the agency's historically siloed approach to quality reporting, consisting of four programs under one umbrella. To reduce burden, CMS should award credit in multiple categories for overlapping efforts. For instance, clinicians should receive credit in both the quality and ACI categories when they report quality measures via end-to-end electronic reporting using certified electronic health records.
4. **Provide clear and actionable feedback about MIPS performance at least every calendar quarter,** as recommended by the statute. Without timely feedback, MIPS is essentially a reporting exercise that enters data into a "black box" only understood by CMS, rather than a useful barometer practices can leverage to drive clinical improvement.
5. **Release critical MIPS information prior to the start of the performance period.** To participate successfully and, more importantly, implement evidence-based actions at the point of care, groups need time to plan and review key program details, such as the quality measure specifications and benchmarks, qualified vendor lists, and clinician and group practice eligibility determinations.

⁴ MGMA 2017 Regulatory Burden Survey, *Summary of Findings*, available at www.mgma.org/regrelief.

Support the development and availability of physician-focused APMs

MGMA agrees with Congress that APMs are a key piece of the transition to a value-based payment system. However, in the eight years since it was created, the Centers for Medicare and Medicaid Innovation (CMMI) has yet to deliver a robust pathway for interested physician practices to move away from fee-for-service and take on appropriate financial risk for the care within their control. Congress should work with CMS to encourage and support the approval of a large and diverse set of new APMs, particularly before the 2022 performance year when the 5% lump sum bonus is set to expire under current statute. There are several immediate steps Congress could take to work with CMS to significantly expand the APM pathway.

It is imperative that CMS revisit the unnecessary regulatory restrictions placed on current Medicare APMs, such as the arbitrary 50-clinician cap for the Comprehensive Primary Care Plus Program and “primary care focus” limitation to qualify as a Medical Home Model. Congress should also direct CMS to establish a separate, lower risk threshold for such practices. In many cases, small and rural practices interested in joining an APM have limited capital and resources to take on financial risk, particularly when compared to larger health systems. Expanding the definition of Advanced APMs to include federal payers other than traditional Medicare would also quickly expand participation. MGMA is encouraged by CMS’ plans to implement a Medicare Advantage (MA) demonstration, although we encourage CMS to consider participants as qualifying Advanced APM participants as opposed to merely exempt from MIPS.

We commend Congress for creating the Physician Focused Payment Model Technical Advisory Committee (PTAC) and its continuing support of the important role PTAC plays in the development of APMs by explicitly permitting PTAC to provide model developers with initial feedback under the Balanced Budget Act. However, PTAC’s work is only valuable if HHS acts on its recommendations. Unfortunately, in a June 13 letter, the Secretary of the U.S. Department of Health and Human Services (HHS) wrote that HHS would not test the APMs that were developed by frontline physicians and withstood rigorous review by PTAC. The chair and co-chair of PTAC expressed frustration with HHS’ lack of direction and inaction during a congressional hearing before the Energy and Commerce Health Subcommittee last November. We urge Congress to direct HHS to be more collaborative with PTAC and to codify a timeline by which the Secretary is expected to respond to PTAC recommendations. MGMA believes sixty or ninety days would be appropriate.

The key features that make APMs less burdensome and a more appealing alternative to one-size-fits-all MIPS are choice and flexibility. These core principles are violated when the federal government mandates participation. According to a recent MGMA poll, 72% of over 1,100 medical group practices who responded opposed mandatory participation in Medicare APMs, citing lack of evidence and a negative impact on practice innovation.⁵ Rather than taking a shortcut to boosting numbers by mandating participation in certain models, CMS should focus on continuing to develop new APMs that meet the needs of a diverse range of practices of varying types, sizes and specialties that will inherently drive more widespread participation.

Participation in Advanced APMs has been slower than anticipated, due in large part to the slow pace at which new models have been developed. Since 2017, just one new Advanced APM has

⁵ “MGMA Poll: Medical group practices oppose mandatory Medicare alternative payment models.” mgma.com/stat

been announced. As a result, CMS estimates less than 250,000 clinicians will participate in Advanced APMs nationwide this year.⁶ Many practices, particularly specialty practices, may be interested in joining Advanced APMs, but are unable to do so because there are not yet viable options. The 5% bonus Congress instituted under MACRA is a powerful incentive for practices to participate in APMs, but it is set to end by 2022. Congress should consider extending it to continue incentivizing practices to participate in APMs as more models are developed that may offer practices an opportunity to participate in an APM for the first time.

Conclusion

Thank you for the opportunity to share our statement regarding implementation of MACRA's physician payment policies. MGMA stands ready to work with Congress, HHS, and other stakeholders in ensuring the QPP supports physician practices' transition to value-based care delivery models by reducing administrative burden, improving the clinical relevance of MIPS, increasing opportunities to move into APMs, and modernizing outdated federal rules impeding care coordination. Should you have any questions, please contact me at agilberg@mgma.org or 202-293-3450.

Regards,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

⁶ 82 Fed. Reg. 30011, *Medicare Program; CY 2018 Updates to the Quality Payment Program*, CMS-5522-P.

