Hearing on the Implementation of the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)

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BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

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C O N T E N T S

WITNESSES

Adrew Slavitt
Acting Administrator, Centers for Medicare & Medicaid Services

Witness Statement [PDF]

IMPLEMENTATION OF THE MEDICARE ACCESS & CHIP REAUTHORIZATION ACT OF 2015 (MACRA)

Wednesday, May 11, 2016
House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, pursuant to call, at 2:05 p.m., in Room 1100, Longworth House Office Building, Hon. Pat Tiberi [chairman of the subcommittee] presiding.

Chairman Tiberi. The subcommittee will come to order. Good afternoon everybody. So we are going to begin. I am really excited to finally be having this hearing.

When I came to Congress back in 2001, the sustainable growth rate, or SGR as we all know it by, a provision in the Balanced Budget Act of 1997, was in the process of being implemented, and under this payment formula, any yearly increase in per beneficiary spending that exceeded growth in GDP could result in a negative adjustment for physician payment in Medicare.

Dr. Price was really well aware of that. Clearly, this policy or the math didn't work, and for the next 15 years we had almost yearly struggles over what was aptly named the "doc fix." Seventeen of these doc fixes later takes us to last March when we came together in a bipartisan fashion with stakeholder input and CMS technical support to pass the Medicare Access and CHIP Reauthorization Act of 2015, or now commonly known as MACRA. With nearly 400 votes in the House, this legislation finally put an end to the sustainable growth rate so that doctors could focus on patient care and not worry about unpredictable payments.

We have called this hearing today to take our first look at the regulations released by CMS on April 27. We will look closely at how these regulations match up with congressional intent and what our members and CMS are hearing from stakeholders as they digest 950 plus pages of regulations.

That is the scope of the hearing, to discuss the implementation of this truly historic legislative feat, and there is a lot in the proposed rule to discuss. So I know that on a bipartisan basis we are going to dive in, in a deep way.

Furthermore, I would like to take a moment to encourage members of both sides of the aisle, as you hear from stakeholders and constituents regarding concerns or thoughts about the proposed rule, please bring them to the attention of the bipartisan committee staff so that we can continue to do robust oversight and keep CMS up to date on the information as they formulate their final regulation.

The passage of MACRA last year confirmed our commitment on both sides of the aisle to keep Medicare strong for America's seniors. This is particularly important to me as well as many of you, especially after we just celebrated Mother's Day as both my parents, back in my district in Ohio, depend on this important Medicare program.

By replacing the way that physicians are paid and consolidating the separate quality measurement systems, we have taken a great step toward the ultimate goal of fully integrated value based care through the incentivization of high quality care. Now our role, as Congress, is to provide oversight, and in conjunction with CMS, to provide education on how this new law will work for the various types of clinicians and provider groups.

We need to answer how this rule will affect individual and small group providers versus larger groups. How will this rule affect specialty groups versus primary care physicians? How will the timing work for implementation under some potentially tight timelines? These are questions that I hope to get clarity on today in going forward through the implementation process.

As we move forward with implementation, I want to make sure that we, as Congress, recognize some very important facts regarding the law that we passed. The merit based incentive payment system, or MIPS is, and was, created as a budget neutral program. High quality value based care will take effort.

As I said before, such efforts must be recognized within the environmental and timing factors based in reality. And additionally, the thresholds for providers to qualify as advanced alternative payment models are high and are set in statute. Working on a bipartisan basis with stakeholders from every corner of our country in an open dialogue and cooperation from CMS will allow us to follow MACRA into the next generation of value based health care.

Now we can go to work. With that, I would like to yield to the distinguished ranking member, Dr. McDermott, for the purposes of an opening statement.

Mr. McDermott. Thank you, Mr. Tiberi.

When Medicare was put in place some 50 years ago, a critical decision was made by the medical association in order to have them join in the effort, and they demanded that they be paid their usual and customary fees, and we, on this committee, have been, since that time, trying to get back the keys to the Treasury. This is another effort here.

Now, the proposal by MACRA, or the MACRA rule from CMS is really as a result of our efforts, as Mr. Tiberi says, of 15 years of realizing what we put in place didn't work. It took us 15 years to figure out that we got to try and do something different.

Now, I hope this is the beginning of a constructive bipartisan conversation about how to advance our shared goal of controlling costs and improving the delivery of health care in the country. Passing MACRA was a tremendous bipartisan accomplishment in that it put an end to a cycle of dysfunction. We had the same thing happen every year. We are going to have a 20 percent cut in doctor's pay, so there would be a big rush around here and we would put a patch on it. And then we go on for another year, and next year it will be a 24 percent cut in doctors pay, and we put a patch on it. We did that again and again. For years we lurched from crisis to crisis. And to avoid what were draconian cuts in the physician's payment, we ended up by spending more on those temporary delays than it would have cost to do away with the SGR in the beginning.

But last year, we put an end to this cycle once and for all by passing MACRA, I was a

trying to step forward, as MACRA is much more than just simple repeal of SGR. It is also the most significant payment reform the Medicare program has seen in years. Thanks to MACRA, we have set Medicare on a more sustainable course that will allow us to pay for volume in health care -- or excuse me, value in health care, rather than volume. The law modernizes and streamlines physician's payment. Instead of a patchwork of incentives and alternative payment models, it consolidates various programs into a single framework, it will allow flexibility for providers, it will allow them to practice medicine independently while still holding them accountable for providing high value care.

These are complicated issues, and we are still in the early stages of digesting this proposed rule. It is big enough. It will take awhile. But what we have seen so far has been encouraging. The administration has worked diligently to implement the law as intended through a process that is responsive to the needs of the public.

The proposed rule is consistent with the goals of MACRA. It provides flexibility to participate either in the merit based incentive payment program, or alternative payment methods that reward high value care. This will make sure providers do not end up in a one-size-fits-all approach and it doesn't make sense to them or their patients. It is the product of an open and transparent process that began months ago through active outreach, consideration of extensive comments, and public workshops with stakeholders, the agency has heard from a range of viewpoints, and the proposal reflects careful consideration of that input.

I am confident the administration will continue to be responsive to the needs of the public as it develops the final rule. This is an ongoing conversation. We still have much more to learn as we work toward our shared goal of making the implementation of this landmark law a success.

Getting the people covered by health care is one thing. Controlling the cost is another thing, and this is about controlling the cost, and I don't believe we have got our arms around it yet, but we are in the process, and that is why we welcome you here, Mr. Slavitt, to make this presentation. Thank you.

Chairman Tiberi. Thank you, Dr. McDermott. Without objection, other members' opening statements will be made part of the record.

Chairman Tiberi. Today's witness panel includes just one expert, and we are lucky to have him, Andy Slavitt, acting administrator at the Centers for Medicare and Medicaid Services, who, along with his colleagues, have the daunting task of implementing this very important law.

On a personal note, thank you for having me at your office yesterday. It was nice to get to know you and members of your team, and I look forward to continuing dialogue in the future.

With that, Mr. Slavitt, please proceed with your testimony, and we appreciate you being here today.

STATEMENT OF ANDREW SLAVITT, ACTING ADMINISTRATOR, CENTERS FOR MEDICARE & MEDICAID SERVICES, (WASHINGTON, D.C.)

Mr. Slavitt. Thank you. Thank you, Chairman Tiberi, Ranking Member McDermott, members of the subcommittee, and thank you for the opportunity to discuss CMS' work

to implement the Medicare Access and CHIP Reauthorization Act of 2015.

We greatly appreciate your leadership in passing this important law, which gives us the unique opportunity to move away from the annual uncertainty created by the sustainable growth rate to a new system that promotes quality, coordinated care for patients, and sets the Medicare program on a more sustainable path. Our number one priority is patient care. And thanks to Congress, MACRA streamlined the patchwork of programs that currently measure value and quality, into a single framework called the "Quality Payment Program" where every physician and clinician has the opportunity to be paid more for providing better care for their patients.

In recognition of the diversity of physician practices, Congress created two paths. The first allows physicians and other clinicians a new flexibility to participate in a single simplified program with lower reporting burden and new flexibility in delivering quality care.

The second path recognizes that physicians and clinicians who choose to take a further step towards care coordination by participating in more advanced models like medical homes. Our goal is make both of these paths flexible, transparent, and simple so physicians can focus on patient care, not reporting or score keeping.

We have approached this implementation with the belief that physicians know best how to provide high quality care to our beneficiaries, and we have taken an unprecedented effort to draft a proposal that is based directly on input from those in the frontline of care delivery. We have reached out and listened to over 6,000 stakeholders, including State medical societies, physician groups, and patient groups to understand how the changes we are proposing may positively impact care and how to avoid unintended consequences. The feedback we received shaped our proposal in important ways, and the dialogue is continuing. Based on what we learned, our approach to implementation has been guided by three principles.

First, patients are and must remain the key focus. Financial incentives should work in the background to support physician and clinician efforts to provide the highest quality care and create incentives to more coordinated care.

Second, we are focused on adopting approaches that can be driven at the practice level, not one-size-fits-all from Washington. It will be important to allow physicians to define the measures of care most fitting with their patients.

Third, we must aim for simplicity in everything we do. Physician practices are already busy, and we are seeking every opportunity possible to minimize distractions from patient care by reducing, automating, and streamlining existing programs. Among the many places that we seek feedback during the comment period, this is among the most important as the burdens on small and rural practices, in particular, have increased over the last several years.

One of the important opportunities will be for physicians to define and propose new payment models so that we can create an array of customized approaches that reflects the diversity of care across the country, and particularly as it relates to the various specialties that provide care.

Congress had the foresight to create a formal voice for physicians through the physician focused payment model technical advisory committee. I had the opportunity to meet with them last week and can tell you that they are very eager to move forward with their important work, and we are eager to work with them.

With all the work that went into this proposal, it is critical that we receive direct feedback from physicians and other stakeholders and are undertaking significant outreach efforts. Our proposed rule is the first step in the process, and we look forward to receiving and reviewing comments to refine and improve our approach.
In the month of May alone, we have 35 scheduled events and listening sessions to hear from a wide range of stakeholders, and this outreach will remain an important part of our work. I personally have been meeting regularly with physician groups, including smaller and rural practices, and have spoken to thousands of physicians in different parts of country about their work, the opportunities and challenges they face, and what this proposal means for them and their patients.
Throughout this, I have appreciated the open dialogue with this subcommittee and the larger committee, and it is clear to me that we share the goals of creating a more sustainable system with smarter spending and it keeps people healthier.
We are striving to do just that in the implementation of MACRA, but it will take work and broad participation to get it right. I look forward to hearing your further thoughts on this implementation and to answering your questions. Thank you.
Chairman Tiberi. Thank you, Mr. Slavitt. As you know, in my district, I represent urban, suburban, rural, and most of the concerns I have heard with respect to MACRA and the future implementation of MACRA is from small and rural providers' practices.
So the proposed regulation assigns three levels of risk required for entities participating in the APMs, the alternative payment models. And what I have not seen are any tiers or variabilities in the amount of risk for participation between an individual and small group clinician and large group clinicians.
Have you heard concern from providers about this?
Mr. Slavitt. Thank you for the question. I think the topic of particularly small practices and making sure that they can succeed is of utmost importance, and our data shows that physicians that are in small and solo practices, so long as they report, can do just as well as physicians in larger size practices.
So we know, however, that there is a burden on us to make the reporting as easy as possible. We also know there are a number of other steps that we need to be looking for, and looking out for, to make sure we make things as easy as possible and accommodate smaller practices.
So importantly, we are looking for additional steps and ideas as people review the rule, but I will say that we are focusing on technical assistance, providing access through medical home models, opportunities to report in groups, and using a reporting process that automatically feeds data, reduces the number of measures, and overall lowers the burden for small practices.
Chairman Tiberi. So in a followup to that, in reading through the regulation, there are several areas that seem to allow a little more flexibility for individual and small group practices. Can you outline some of the major differences in reporting for individual and small group practices versus the larger groups that could maybe ease the burden or send that message to the smaller groups that there is sensitivity there?
Mr. Slavitt. Sure. Absolutely. First of all, at the request of the physician -- we met with a lot of physicians and physician groups and small practices in this process. One of their key requests was that if they are already participating in something like a clinical registry or some other way of getting data across that may be an accountable care organization or

clinical registry, that we use that information rather than requiring them to send them again, and our proposal does indeed allow this multiple ways for us to get information. Secondly, we are required to measure the cost of care, and we are going to be able to do that automatically by getting a claims fee, so it is going to require physicians to send us no information whatsoever. And then there are a number of areas where they will simply need to attest to whether they are doing a certain activity, which we think will reduce the burden, and we are looking more broadly at the overall experience for physicians. Small physicians can report in groups in many categories where they hadn't been able to before, and then finally, I would say, there are a large number of physicians who won't have to report at all because they will be underneath their minimum threshold. And Congress put forward that if physicians don't see enough Medicare patients or enough amount through Medicare, that they don't have to report at all.

So all of those things, I think, are there. And again, we also look for additional steps, if there are some, that we can take.

Chairman Tiberi. Just a final thought, and I don't mean to put you on the spot on this, but do you think there is any more that we can do, those of us on this side of the dais, and you and your team at CMS, that we could do to ensure that, as we lay the foundation for MACRA going forward and there is buy-in, complete buy-in from the physician community, that the system is not built with an inherent fairness or fairness issues -- again, going back to the rural provider or the two-person provider group that has a bunch of angst right now --

Mr. Slavitt. Right.

Chairman Tiberi. -- as this has begun to unfold. Is there anymore that we can do, or you can do, or we can work together on?

Mr. Slavitt. Yeah. I think it has got to be a vital continuous effort. Last week I met with small physician practices from southern Arkansas, southern Oregon, and New Jersey. We have a meeting on Friday with Rural Health Association at their annual meeting. We went out to Kansas City last week to meet with the Family Practice Association, and we do hear a lot from small physicians who are concerned, and I think they are particularly concerned if people in Washington are making centralized decisions that are going to impact their quality of care.

And what they tell us over and over again, and we need to keep talking to them and getting more feedback, is give us the freedom to take care of these patients. We know how to do it, let us define quality, let us select the measures that are right for our practice, give us more flexibility, and don't make us focus on reporting. Let us focus on patient care. And it is really critical, I think, as we work together and as you hear input, that you get this to us and that we hold ourselves very much to that standard that physicians across the country are holding us to.

Chairman Tiberi. Thank you, sir. With that, I recognize Dr. McDermott for 5 minutes.

Mr. McDermott. Thank you. One of the issues that the questions Mr. Tiberi is raising about small practices sort of leads me to the question of consolidation and driving doctors together in larger and larger groups. The question then comes in my mind -- I practiced both as an individual, and in the military, and in a group practice, so I have been in all sorts of forums. One of the things that strikes me that is going to be difficult to deal with here is the whole question of what is the best care.

If you have a large organization and they have an MRI and they don't want to use it, or

they want to use it, they can crank through a lot of people through an MRI for everything, or they can say don't use an MRI, and there will be patients out there who do not benefit from what they could find. I can give you an example of a young woman, 34 years old who had pain in her back, and was told there was -- you know, you are riding a bicycle, and there is a lot of reasons why, you know, you are young, and blah, blah, blah.
At 35, they did an MRI and found a tumor in her spine. Now, if they had done that, they would have found it 5 years earlier, but the organization was encouraging people not to use. So how are we going to make our judgment about whether we have got quality of care, if the major factor is going to be money? I mean, what is built into this to actually look at the quality of care?
Mr. Slavitt. Yeah. So I think at the heart of question, the most important thing above all else is making sure patients get high-quality care, and we do believe that if patients are getting high-quality care, that is going to lead to better cost control because if someone gets the right surgery, they won't need to have a second surgery.
Likewise, quality is also defined as making sure the care is coordinated, so if somebody needs to have a followup visit or has a prescription or something with an instruction, that they understand what that is, it is explained to them and that the system works and supports them. So our job here is to enforce that, number one.
Number two, I think our job isn't to define quality here ourselves as much as it is to take the best standards of care that the specialists and the physicians around the country have defined as quality and make sure that we keep up with that and that we keep those measures as the things that physicians decide, as a group, that they should be measured on, and those are the things -- and then third, as I said earlier, that at the practice -- things actually differ at the practice level.
And we believe the practice is, by and large, are the people that know best for what is right with their patients, and that the dialogue between the patient and the physician -- so nothing we are doing should be seen to be interfering with that in any way. And in fact, we ought to be reinforcing those things, and I think MACRA gives us the opportunity to say if you are delivering a better quality of care outcome for your patient, you ought to be rewarded for that.
Mr. McDermott. You are suggesting the whole question of evidence based medicine, that is, I mean, I have been to the doctor recently, and they send out, from the University of Washington, a sheet to me, and it says did you have good care. Well, was he polite, was he nicely dressed, and blah, blah, blah, down at the bottom, were you satisfied with your care?
Now, for some people, if they don't get a prescription or they don't get an X-ray or they don't get a blood test or they don't get something, they haven't had -- the doctor hasn't done anything.
Mr. Slavitt. Right.
Mr. McDermott. So how do you measure then the patient who says, well, I wasn't satisfied because I went away and I still ain't got -- my sinuses are a mess and he didn't give me antibiotics. How do you deal with that issue in the quality of care?
Mr. Slavitt. Sure. I think one of the nicest things is -- I will give you an example. I was sitting down with some physicians that are practicing medicine in southern rural Arkansas, I referred to them recently. They are in one of these models, a medical home

model, where they have a per member, per month payment they get in order to coordinate the care, and they have hired care coordinators, and what they told me was, the physician I was talking to told me, he said is, now I actually can get paid to practice medicine the way that I am supposed to practice medicine instead of practicing medicine the right way and getting paid on something completely different.

So I think the more we evolve our healthcare system to a way that reinforces what physicians know are the right things to do in delivering quality of care to patients, the better off we are going to be, as opposed to a system where if you don't make a cut in someone's skin or give them a prescription or something that they leave the office with, that is not success.

Mr. McDermott. I have a medical home at the University of Washington. Thank you.

Chairman Tiberi. Thank you, Dr. McDermott. That was really good. We agree on something.

Mr. Slavitt, thank you so much. You know, I have got 12 different questions I could ask you on 12 different topics, and my mom has one that she shared with me last night she wanted me to ask you. But it doesn't have to do with MACRA, so that is for another day, and I would like to remind all members to try to keep the topic to this important law that we passed.

With that, Mr. Johnson is recognized for 5 minutes.

Mr. Johnson. Thank you, Mr. Chairman.

Mr. Slavitt, welcome. You have said that CMS is working to regain the hearts and minds of physicians through implementation of MACRA, and that is great because many physicians in solo and small practices have really struggled to stay afloat in recent years. And while there are a lot of good things in the proposed rule, I have one issue I would like to raise with you. I am concerned by the estimates in table 64 where CMS projects the greatest negative impact on payments to practices with 9 or fewer doctors and the least harm to large systems with 100 or more docs. If CMS is trying to win back the hearts and minds of physicians, this proposal falls short since it will continue to push physicians out of their solo or small practices.

Can you tell me specifically what CMS is doing to ensure that solo practitioners and small groups can succeed under the MIPS and participate in alternative payment models by 2019?

Mr. Slavitt. Thank you. Thank you, Congressman Johnson, for the question, and I really would actually welcome the opportunity to address this table, and for anyone who hasn't seen the table, the table is designed to estimate what the impact of these regulations could be on practices of various size.

And the first thing I want to make very clear is that the question of making sure that small groups and solo practitioners can be successful is of utmost importance, and I would also indicate that despite what that table shows, our data shows that physicians who are in small and solo practices can do just as well and actually do do just as well as physicians that are in practices that are larger than that.

Now, the reason that table looks the way it does is for one very simple and important reason. It accounts for the fact, that in 2014, when the table the data uses, most physicians in small and solo practices did not even report on their quality, and this is important for a couple of reasons.

First of all, I should say that in 2015 and subsequent years, the reporting went up, so at

best, this table would be very, very conservative, and of course, as I explained to Chairman Tiberi, reporting is going to get far easier going forward.
But it does point to a couple of things that I think we would be wise to pay attention to. One, making sure that it is as easy as possible for physicians to report. One of the reasons why we don't have the hearts and minds of physicians is because there is just too much paperwork in health care.
Mr. Johnson. I would agree.
Mr. Slavitt. They need to be practicing medicine, not doing paperwork. So there has been a tremendous amount of effort so far, and this is just a proposal. So this next period of time for comments are a time when we are hoping people can give us even further ideas and further ways that we can reduce the administrative and reporting burden. But to be very clear, there is absolutely every opportunity, and in fact, an equal opportunity for small and solo practices to be successful.
Mr. Johnson. Well, thank you. Maybe we better indoctrinate the nurses, too. Don't they do most of that?
I thank you, Mr. Chairman. I yield back my time.
Chairman Tiberi. Thank you, Mr. Johnson.
Mr. Kind is recognized for 5 minutes.
Mr. Kind. Thank you, Mr. Chairman. Thank you, Mr. Slavitt, for your testimony here today. Needless to say, I think Congress, in passing MACRA, gave you a huge undertaking, and now with a 900-page rule, I think it is pretty obvious that we are going to need to keep the lines of communication open, and hopefully your outreach with the stakeholder groups will continue as it has been, not just physicians but patient feedback as well.
I know many members of this committee, myself included, have been pushing hard to move to a more integrated coordinated healthcare delivery system. I come from a region of the country in Wisconsin that established models of care, and been pushing aggressively in this direction for quite some time. And then ultimately, you know, alternative payment methods so we get the quality, value based, outcome based reimbursements. And again, that is kind of the directive that MACRA gave you.
But also a lot of my providers were early stage first generation ACO models. My question is, what more can be done in order to provide an on ramp for advanced APM payments to those early stage ACOs, or are they going to have to just leapfrog and go on to Gen 2, Gen 3, Gen 4?
Mr. Slavitt. So you are raising a very important question, which is where physicians have an opportunity -- as we mentioned, all physicians in every program will have the opportunity to get rewarded for quality care, but where physicians have an opportunity to and have had the opportunity over the last several years, to join with other physicians in these more coordinated care models, the medical home would be one example, we think those are a good idea. We think they are a good idea if they are right for the physician, if the physician think they make sense for their patients, and of course, it creates an opportunity in its own right to earn more.
What MACRA does is it gives physicians even an additional opportunity and an opportunity to earn 5 percent additional bonus on top of what they may already be earning in these advanced models. So the question is: What is the requirement to get access to that 5 percent bonus? And the legislation puts forward a number of

requirements, and the requirement really, in a nutshell, if I were going to simplify it, is that there has to be a higher degree of shared accountability from the physician, and that shared accountability is shared accountability for the outcome to the patient and a minimal sharing of the costs with the Medicare program itself.
So in other words, in order to qualify for this 5 percent bonus, I think the words that are in the legislation are there has to be a more than a nominal risk.
So our job in putting this regulation together is to put the definition around what is that nominal risk. We have tried to do that in as consistent a way as possible and as simple a way as possible, but really we are -- one of the areas where we really are inviting feedback. And then all of our models, whatever model we are in, will have to qualify based upon that definition.
And so even if a physician is in a model that doesn't qualify because there is not as much nominal risk, there is still great opportunities, and there is still opportunities for them to grow into other models.
Mr. Kind. Well, finally, you know, the great cost driver in our society, and it is true at the Federal level at the budget, at State and local, for families and businesses alike, of rising healthcare costs. So with the direction this rule is taking, can we sit here with reasonable confidence that this may ultimately lead to some cost savings but without jeopardizing the outcome or quality of care that our patients are receiving? Or this going to turn into a Lake Wobegon type of situation where everyone is above average, everyone is qualifying to bonus payments, and there is no real cost savings at the end of the day?
Mr. Slavitt. Right. Well, I think, first of all, we all are striving for a higher quality healthcare system. We all want our money spent more wisely, and we don't want to do it in a way that people feel like they are getting -- skimping on their care. We have 10,000 new seniors every day in America, and our jobs are to be able to figure out how to take care of them better for less money. And that means being able to take care of them in lower cost settings, more comfortable settings like their homes rather than in institutions like hospitals, and so those types of incentives are vital to this program.
Within the regulation, there are -- the pool balances out, and so we are going to have to allocate money and have upward and downward adjustments as part of this program in order to be able to meet the sustainability test you talked about. That is nothing new. There are upward and downward adjustments in programs today. What is new is that this will be a simpler more aligned program that is easier to measure and take attack of.
Mr. Kind. Great. Thank you. Thank you, Mr. Chairman.
Chairman Tiberi. Mr. Roskam is recognized for 5 minutes.
Mr. Roskam. Thank you, Mr. Chairman. Mr. Chairman, I have got an observation, a point, and a nudge.
My observation is this: There is a level of anxiety that is out there in our public life today because people look at Congress and they say nothing is happening. And yet here we have got this issue where both sides of the aisle, the White House, everybody came together, wrestled a very complicated issue to the ground, came up with a solution, and it doesn't involve snarling at one another on television, it doesn't involve, you know, a hyperbole and so forth, but there was this very serious effort, and we are on the verge of, I think, some good things.
So just a little shout out, and that is, three cheers for something getting done, and I think

there is an encouraging element to that.
My point is that debate matters. I would argue that one of the reasons that we were able to have that discussion, when Speaker Boehner and leader Pelosi were able to come together, and the two of them really drove the discussion, it was because it had been well wrestled through in the United States over the past several years that we need to do something on Medicare. And both sides have different views of the world and so forth, but it had become normalized in that sense that these things had to change.
So debate does matter, and I think we are better off if our debate doesn't involve snarling at one another, and it is two various points, but debate matters because debate is a prelude to action. Margaret Thatcher said: First you win the debate, then you win the vote.
Okay. Now here is the nudge, and this is the nudge for you, Mr. Slavitt. One of the things that I think you and I have talked about offline, and you have alluded to some of this, too, a minute ago, there is this tension that is out there, and there is a tension that manifests -- and let me just tell you a quick story.
I served in the State legislature, and we had some education testing issues that came before us, and you know how this works. There is always a new test, there is always a new standard, so I called a friend of mine, who is an old friend from high school, who is a high school administrator, and I said: Give me the straight scoop on these tests.
And he said: Peter, look, will you just pick a test and stick with it and not change it every 4 years? He goes: We are happy to be accountable, but stick with the test, stick with the program. And that deeply resonated with me.
So the tension is that I think healthcare providers want a standard, they want something that is predictable, but now, also, the tension is they don't want something that is declarative and dispositive and can never be revisited because that is big and that is overwhelming and that is what SGR had -- that is what we had to do for, you know, the doc fix for all those years. That was declarative. It was an overcharacterization, and it failed. And the proof that it failed was you had to kick -- we all had to kick the can down the road.
So my nudge is this: As you are going through and you are figuring this out -- and I really appreciate the disposition and the attitude and the open rule time that you have now and the comments that you are taking in, if you could really be mindful of those smaller practices that Mr. Johnson mentioned, the point that Mr. McDermott made, and that is, how is it that a physician that is stewarding antibiotics correctly or not giving in to patient pressure for a prescription, how is that physician protected. Also, I hadn't thought about it until Mr. Kind mentioned it, are the bonus payments, a new floor, and does the average become the expectation?
So,I am here, and I think that the chairman has set the great tone here, and that is, for us to listen and to learn, but as you are navigating through those natural tensions of having something that can be predictable but also maintaining that level of flexibility where it can be revisited and changed, I think is the best of both worlds.
And with that, you don't need to respond. I'll yield back. Thank you.
Chairman Tiberi. If you would like to respond, you may. Up to you.
Mr. Slavitt. We had this conversation, including a little bit yesterday. I think this idea of making sure that people don't feel like the game is changing on them, made porous, is critical. So there is enough in this legislation that allows us to tell folks going in, hey, here is how it works, in advance. I think there is nothing more frustrating than being told

after you took the test how it is being graded.
And then I think you make an important point as well, which is how do you trade off making sure you are predictable, with staying current, with the state of the art of the state of medicine, and what physicians are saying that they want, and I think we have a process for that, we take comment on that process, we think it is an effective process, but it is also important that physicians have the flexibility to navigate the process, particularly at different times in their practice.
Chairman Tiberi. Thank you. Mr. Thompson is recognized for 5 minutes.
Mr. Thompson. Thank you, Mr. Chairman, for having the hearing today. Thank you, sir, for being here. I am sorry I had to step out, so I hope I am not going to be repetitive here. But we are all very, very interested, I think you can tell by the tone of all the questions, that this law works. We have a very vested interest in that, not only as a committee of jurisdiction, but also these are the people, providers, and patients that we represent at home, and we want to make sure that it works.
And so to that end, I would like to hear what the administration is doing to help providers get ready ahead of the 2017 start date, and what would you recommend providers be doing to get ready, and is there anything that we, as Members of Congress, should be doing to help facilitate this transition?
Mr. Slavitt. Yeah. Thank you. So I guess maybe I will start to direct that question as if what I would say to a physician who was wondering what does this all mean, and it is a conversation that I get to have frequently because I have been having a lot of conversations with physicians, and I think there are probably 5 things I would say that I would keep in mind as a physician or from, I think, our perspective.
Number one and most importantly, keep focussing on your patients and on patient care. Don't worry about the score keeping. It will be our job to put this forward in a way where it becomes easier, and indeed, it will be easier and more streamlined than the processes that people have to go through today, so that is the good news, and that is the first thing.
The second thing is, we have to continue to talk to people and educate people as there are opportunity. As the chairman's question implied earlier, is that because physicians will have the opportunity to decide which measures and which ways the measuring quality they want to be measured on, that at some point they will be able to think about what those things are and they will be able to put those in motion, and that is really one of the important early things.
I think if there are opportunities to participate in these more advanced models, these care coordination models like medical homes, they should obviously consider those because there are some extra rewards for that, but it won't be until the spring of 2018 that physicians would first need to report on MACRA. And so it is important that they not get too concerned about that.
And then the final thing I would say, and I think as we are trying to encourage for everybody is to provide us feedback. During this comment period, we really want physicians to be able to review this. We are setting up a number of sessions. I talked to 3,000 physicians yesterday on a call. We do twice a week webinars to get your questions answered and then give us feedback on how you think this is going to affect your practice.
Mr. Thompson. And as far as us being able to do anything to help facilitate the

transition, any comments for the committee?
Mr. Slavitt. I think the more listening sessions and open forums that there can be with physicians, and giving physicians an opportunity not just to hear what is in the rule but to tell us how it is going to impact them -- I spoke with one of the members of the subcommittee who asked me to participate in one of those sessions with people in their -- in his district, I think we have a lot of the staff at CMS that are available to do phone calls and other things to reach out directly, so let us know what you are hearing from your constituents, and our job is to be responsive.
Mr. Thompson. And so in my particular case, would you rather do a phone call to the Napa Valley or would you rather come out and do it in person? I yield back.
Chairman Tiberi. Maybe a future subcommittee hearing.
Dr. Price, recognized for 5 minutes.
Mr. Price. Thank you, Mr. Chairman, and thank you, Mr. Slavitt, for joining us today. I think, as has been said, I think we are moving in a better direction, but we still have a long way to go, and if we are going to make it so that physicians can once again be able to care for patients without an inordinate amount of influence or burden from outside, we have got to continue to work through this, and I appreciate your willingness to do so.
I have got a couple of specific areas, and then I want to tick through.
One is you have got the moving from meaningful use to ACI, whatever we want to call it, we got the 365-day rule. In the past, it has always been a 90-day rule, which means that the practice has to demonstrate that they comply for a 90-day continuous period within a 365-day period.
It only makes sense, nobody is perfect every day, and if they are going to get dinged because they are not able to comply 1 day or 2 days or 3 days, then we have simply got to move to a 90-day, and I hope that you are able to work in that direction.
Mr. Slavitt. So it is one of the key areas we are inviting comment right now during the comment period.
Mr. Price. Good. So I invite comment as well from folks from whom I have heard.
Mr. Slavitt. Okay.
Mr. Price. On the alternative payment models. You have got a lot of folks out there, a lot of docs, guys, and gals who have already modified what they are doing. The bundled payment, BPCI programs, the future CJR program, and yet it appears that those programs, that CMS has pushed on docs, and encouraged docs, and incentivized docs, don't even qualify for APMs. That doesn't make any sense at all.
So I hope you are looking at just grandfathering those or moving them in or allowing them to qualify as APMs.
Mr. Slavitt. So Congressman, one of the things that I think we have to do now that the law is being implemented is to go back and look at all of our models and see where we can make changes to them so that the participants in them can qualify. And I know that Dr. Conway is very much directing the team to look for ways to do that where possible. They have to meet -- there are certain requirements that have to be met.
An example would be what percentage of the patients I am seeing are part of this bundled payment, and so that is because that is in the statute and the law, we have to look at how we can modify these programs or work with you on what our flexibility is to be able to --
Mr. Price. I agree. If you expand the ability for them to use their entire practice instead

of just Medicare, that oftentimes gets them to that point.
Mr. Slavitt. Right.
Mr. Price. So I would urge you to look at that.
Mr. Slavitt. Okay.
Mr. Price. Docs are really frustrated with things for which they are being held accountable that they have no control over. One of them is on the meaningful use, ACI issue, this data blocking that is occurring by the vendors. Docs don't have any control over what the vendors do at all, so how we can have a system that actually punishes docs or potentially punishes docs because of what somebody else does that they don't have any control over, again, that doesn't make any sense at all, and they are pulling their hair out trying to comply with this, so if you can look at that, that would be appreciated as well.
Mr. Slavitt. Will do.
Mr. Price. I want to touch on the nominal risk that you talked about. The nominal risk, as I understand it, is minimum of 4 percent of total spending to be qualified under an APM.
Mr. Slavitt. That is correct.
Mr. Price. And as you know, the physicians control, I don't know, pick your number, 14, 15, 16 percent of total spending. So 4 percent of total spending is really 25, 30 percent hit for the docs. So how can we have a system that punishes the people that are -- where the rubber hits the road, trying to care for these patients, and again for which they have little control over? Shouldn't that be 4 percent of the physician total reimbursement?
Mr. Slavitt. So one of the areas where we are looking for feedback in the comment period is both what is nominal risk quantitatively? We have chosen a number that was consistent across the MIPS program, but that is just in the proposal.
Mr. Price. Doesn't that presume that the physician controls every dollar of spending?
Mr. Slavitt. And that is the second area that we seek feedback, which is, under what universe total cost of care, which of course the benefit of a total cost of care is a primary care physician has the opportunity to get rewarded for being able to keep the patient out of the hospital and they don't belong there and so forth. Of course, as you point out, it is an area where we are looking for feedback and very much hearing that perspective.
Mr. Price. A lot of those things are out of their control.
Mr. Slavitt. Sure.
Mr. Price. We would like to believe that they control them, but in an ideal world, that might be nice, but a lot of those things are out of control.
I have got a few seconds left, and I just want to point out, once again, the table that you identified, table 64, which by your own data, stipulates that 87 percent of solo practitioners are going to see a negative adjustment. Is your own data. Granted, it is 2 years old, but it is going to be 2-year-old data that is going to reward them 2019 based upon what happens in 2017, so I would urge you to relook at how you are adjusting that, and in realtime, providing an update.
Mr. Slavitt. Right. Right. And we are going to look in the final rule at having the most updated and most accurate information in that table. Again, while that table would not be good news for reality, I don't believe it is reality, however I will say that the silver lining is I think drawing attention to the impact of this regulation on small and solo practices is a good thing, and so I think it is where we need to have dialogue, and so despite the fact that I don't think that table represents the reality, I do think that the reality of how

difficult it is to practice medicine in a small or solo practice is very real, and so we are looking for ways to make sure we make it better.
Mr. Price. Great. Thank you very much. Thank you, Mr. Chairman.
Chairman Tiberi. Thank you. I think you might be sensing a theme up here.
Mr. Blumenauer, you are recognized for 5 minutes.
Mr. Blumenauer. Thank you, Mr. Chairman. I appreciate the opportunity to have the conversation today. Mr. Administrator, I appreciate the approach that you folks have taken to help us turn the corner.
I personally have found the charade we went through for some 17 years kind of embarrassing, dancing away from an event we know nobody had any expectation should happen. We were dealing with a budget fiction.
I think the agreement that was struck is reasonable. There is still much value to be squeezed out of the system, but I appreciate the fact and some of the references from my friend, Dr. Price.
We have got people who are in the middle of practice patterns, limitations on data, and just a whole host of other changes taking place, and I appreciate the commitment to do so in a thoughtful and deliberate fashion.
You have also heard another theme emerge that people are keenly interested in making sure that we make this transition to rewarding value over volume, and that we have had problems in the past with some things, theoretically. I mean, I have strongly supported Medicare Advantage, but at the same time, the parts of the Affordable Care Act to try and coax more value out of it because, theoretically, it should enable us to deliver care more efficiently, and we continue to have a pretty significant premium.
The compromise that was struck and one that I thought was healthy, was to provide bonuses based on performance and try and deal with some of the areas where there is some decidedly, I don't know if one wants to calls them outliers, but there is some real performance problems being overcompensated, coming from one of those regions that we like to think that if everybody practiced medicine like they do in my congressional district, we wouldn't have the funding problems that we have.
You know, I am looking at charts like this that kind of display how it is supposed to work over time, I wonder if you can just give us a sense of where you think the pinch points are, where will be some of the things that we need to be prepared to be able to work with you, if there is further adjustments legislatively, if there are things that we need to do a better job of just being able to understand ourselves, to explain to our community at home, where are the pinch points you think we need to zero in on?
Mr. Slavitt. Thank you, Congressman Blumenauer. I think I point to a couple of areas that I think are really critical focus areas for us. One is the education and communication process, particularly with smaller practices and individual solo physicians. It is vital that we hear their feedback and understand what the impact of the decisions that we are making here today will be on their practices several years from now. So that education process, I think, means a couple of things.
One is that we talk in plain English instead of acronyms, which we are quite guilty of here, I know, but we are trying very hard to do a better job with that. We have created simple fact sheets, and training sessions, and PowerPoints, and as many options as possible to do that, and to the extent that you can help us do that and tell us what you are hearing, that is going to be critical.

The second thing that I think we will need to continue to hear from you all on, and I think the conversation with Congressman Price, is apropo to this, is where there are places where you think there should be flexibility and how we should be exercising flexibility, whether it is with smaller practices or whether it is in how we define the models that qualify for the 5 percent bonus, and in all of those areas, your feedback on our interpretations are critical because we really do want to get to the best answer.
And I will tell you that we don't have a monopoly on that. We want to do that through the dialogue and the debate that Congressman Roskam referred to, and we also are going to have to make this an ongoing commitment because we will have to look at this program at the end of its first year and understand what worked well and what didn't and what can work better, and we can't be afraid to call out the things that didn't work as well and sit down together and try to figure out how to make those things better, whether it is with technical improvements or whether it is simply in how we are implementing things.
Mr. Blumenauer. Mr. Chairman, I do appreciate the opportunity to get into something, which I hope we are able to periodically update, review. I appreciate part of this as process and part of it is performance, and being able to strike that balance in a way that is protective of the people who depend on this service but also for the taxpayer, I think, is going to be a challenge for our friends at CMS and for the committee, and I hope we can continue sort of zeroing in in that fashion. Thank you.
Chairman Tiberi. Thank you. Well said. Mr. Smith of Nebraska is recognized for 5 minutes.
Mr. Smith of Nebraska. Thank you, Mr. Chairman. Thank you, Administrator Slavitt, for being here today. I represent a very rural district, and some parts more rural than others, in fact. 75 counties touching six States, obviously, we are very spread out. Number one agricultural district in the Nation, very productive. The nearly 60 hospitals in my district, about 54 are designated as critical access, and that might be a single designation, but that is about 54 different types of expertise and providers, and I am actually inspired by the work that they do serving communities from smaller than 1,000 up to about 12,000 plus. Nonetheless, they have got a very large task, and I guess so do you.
Can you discuss the feedback you received from rural providers in response to the initial RFI and how you addressed that in producing the rule and then what rural providers and critical access hospitals can expect from this rule?
Mr. Slavitt. Yeah. Thank you, Congressman. And in your district, and I think throughout the country, you know, we face the challenge of not having enough physicians, in many cases enough specialties, and there are many districts around the country where there are, you know, only one or two providers in certain specialties. So we cannot allow the side show that goes along with the practice of medicine to make the practice of medicine less fulfilling and less rewarding.
So as it relates to the small physician practices, the medical home models that many of them are participating in, we have had really terrific feedback from, and I think what I hear from small physicians is give us the opportunity, find ways for us to have the opportunity to participate in some of these same opportunities, the models that people do in urban settings and make them work for us. So can you make changes to them that can work for us. That is, I think, one of the things we --
And then on critical access hospitals. Obviously, for us, you know, so many of our

Medicare beneficiaries get taken care of and get treated and rely on those critical access hospitals, and the economics of health care in rural America is different than it is in other places. And that is both a short-term issue that we have regulations, as you know, to set and deal with, but it is also a longer term question around how those hospitals are structured, what they provide, and how we support them in the appropriate way.

Mr. Smith of Nebraska. Okay. In your response to the chairman, you had mentioning a reporting exemption for small providers. At the same time I have heard questions from those who fall below the reporting threshold who would like to be able to report data. Will they have that opportunity?

Mr. Slavitt. So that is interesting you say that. I had that feedback last night when -- in talking to a specialty society who said we want our specialty to be more engaged in the practice of medicine with seniors. And so even our physicians, who are only seeing small amounts, we want to do that.

So I will tell you I heard feedback in both directions that I think our job will be, over the comment period, to take all that in and figure out how to do the best job accommodating the most types of practices as possible.

Mr. Smith of Nebraska. Okay. Well, I appreciate that. I know that the providers that I talked to are constantly not just to saying what the problem is but to providing solutions and innovations, and I would hope that we can empower providers to care for their patients without the government getting in the way or messing things up.

Thank you, Mr. Chairman. I yield back.

Chairman Tiberi. Thank you. The former mayor of Paterson, New Jersey is recognized, Mr. Pascrell for 5 minutes.

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

Administrator Slavitt, under your leadership, CMS has stressed the importance of better data to improve quality, to improve outcomes, and has made great strides in making that data available.

MACRA included a provision that allows innovators to use QE data, to help us make smarter decisions. Do you agree that the medical devices used in care -- and I will focus in on that -- particularly for the most common Medicare procedure, joint replacements, play a role in healthcare quality and outcomes?

Medicare has no information on the medical devices implanted in Medicare beneficiaries. I think we should let that settle in for a few seconds. Extremely problematic, I think, from an oversight perspective, and most importantly, from a safety perspective. You and I have had discussions, there is a history here that we need to address.

So shouldn't this information be made available?

Mr. Slavitt. Yeah.

Mr. Pascrell. Administrator.

Mr. Slavitt. Thank you, Congressman.

So the question you raise is really one of should there be, and how should we capture, a device identifier in a unique way on every device, and I think that is the goal. It is a goal that we share. It is a goal that the FDA shares. And it is critical for post-market surveillance to be able to understand the safety of how these devices work.

So there are several, I think, critical things that we can do, and are doing, and are trying to do to make this possible. So despite our enthusiasm for this -- and this is an issue that

has long preceded me. As you know, it has been an issue for quite some time -- there are a number of parties who have a say in the matter of how this happens.
I think as a first step, we are moving forward with the incorporation of a unique device identifier into electronic health records. I think this is a strong step, particularly considering the dramatic growth in electronic health records. But I know that there is also an interest on claim forms that there is a way for providers to provide care to indicate the device identifier on the claim form. We think that also has merit, particularly from a research perspective.
I think there are a couple of issues to making that a reality: One is the committee that essentially designs the claim form, which is made up of a wide group of participants and hospitals and physician groups; second, is making sure that if we at CMS are given the charge to do this that we can fund it and have the funds to do it operationally; and then the third, there will be an education and training process because the history is, that physicians don't automatically put the information they need to down on a form unless it is critical to them getting paid.
So I think we need to work through all of these issues with you. We have pledged to do this with your office, and we are working closely with the FDA to find the best path forward.
Mr. Pascrell. I think you have used the best word, "critical." But if we don't do it this time, then we have got to wait another 15 years before we change those forms, and our seniors will not be well served. This is important. I have been frustrated with CMS's resistance to what I believe is a very important priority, particularly of safety, including the unique device identifiers on health insurance claims.
In order for the UDI to be added, to the claims form as part of the next update, it would go into effect, I think, in 2021. That is the soonest. We need to act now, and I think -- I can't stress enough, Mr. Chairman, we are talking about the safety of the people who use these devices, and we all want to be on the same page. This is, I think, a good time for us to address this issue.
A number of cases, a number of anecdotal stories about not only seniors, by the way, but -- we talked about seniors here because we are talking about Medicare -- that have had the problems, and we need to address that in order to improve safety. Everybody on this committee talks about it, and I believe them and their hearts. Here is a chance for us to do something about it.
But I want to thank you, Mr. Slavitt. You have done a great job and thank you for putting up with us, but we are not going away. Thank you.
Mr. Slavitt. Thank you, Congressman.
Chairman Tiberi. Thank you, Mr. Pascrell.
Ms. Jenkins is recognized for 5 minutes.
Ms. Jenkins. Thank you, Mr. Chairman.
Thank you, Mr. Administrator, for joining us today.
Medicare obviously plays an important role for many Kansans. It is the largest payer for medical services in America, a lifesaving benefit for many people. Last year, over 485,000 Kansans had health coverage for Medicare. We were pleased MACRA passed last year in a bipartisan manner. With the passage of MACRA we repealed SGR and instead put in place what will hopefully lead to a better reimbursement system for physicians.

Mr. Slavitt, the relationship between a physician and a beneficiary cannot be underscored in importance, and I believe this is especially true when talking about seniors. With the moves that MACRA makes towards higher-value care centered on the quality of care administered by clinicians, it is ever important to ensure that we encourage greater and greater communication around decisionmaking between the doctors and their patients. So as MACRA's implementation continues over the next several years, do you see room to begin including patient activation measures, placing greater responsibility on this relationship with the hopeful result of shared responsibility over healthcare maintenance and thus furthering the quality of care?

Mr. Slavitt. Yes. Thank you, Congresswoman, for that. I think that is a really important question, and I think there is an opportunity over the next several years to begin to incorporate those engagement measures in.

There are a few things that are in the current proposal that I would point to that take steps in that direction: One is there is a practice improvement focus opportunity on the creation of a joint care plan between a patient and a physician; secondly, in the advancing care information area, there are opportunities that focus on measures around how patients and physicians are communicating using technology and making sure that information is being made available to patients electronically and through other means.

But I think this is, as you point out, a ripe opportunity and a brand new area of focus for more patient engagement. We have been meeting with a number of patient groups as we have been putting this work together, and that is an important area of feedback for us.

Ms. Jenkins. All right. Thank you, Mr. Chairman. I yield back.

Chairman Tiberi. Thank you.

Mr. Davis is recognized for 5 minutes.

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

Let me welcome you, Mr. Slavitt. I know that you have spent considerable growing-up time in Evanston, Illinois, which isn't very far from my district. And I also know that your mother lives in my district, and I am pleased to tell you that I have not had any real complaints from her, and so that makes me feel good.

Mr. Slavitt. That makes one of us.

Mr. Davis. But let me compliment you on your work. Medicine is a very complex environment, and there is tremendous complexity. And I also want to thank your staff. I have 24 hospitals in my district, four large medical schools, a number of research institutions, and a very activated citizenry. So we get lots of inquiries, lots of calls for assistance, a lot of calls for clarification. And so we spend considerable time not pestering but certainly inquiring of your staff, and I want to thank them for the kinds of sensitivities they have displayed.

I also have a very activate medical community, physicians associations and organizations. Just last week I had a meeting with the Chicago Medical Society. But I have heard concerns that under the proposed rule that we are talking about, only a limited number of physicians will meet the alternative payment model, or APM, criteria to earn the payment bonus.

By your own estimation, you have indicated that there may be only 30,000 to 90,000 physicians who meet these terms, which is a tiny fraction of the total Medicare-eligible doctors in the country, and I am certain that we will hear some more from these physician groups. They would like to know what could make it -- or how likely is it that anything

will make it easier for there to be more pathways to qualify for the APM bonus payments?
And how can CMS improve the opportunities for our physicians to meet the advanced APM criteria, and achieve the incentive to drive better care that Congress intended?
And would you consider additional pathways that qualify as advanced APMs to provide assistance for our physicians who wish to enter the current model?
Mr. Slavitt. Thank you, Congressman. And my mother made me promise to tell you that she was a teacher at Howe and working with Principal Pat Tyco (ph), she knows you well and so she made sure I said this publicly. So I have delivered that for my mother.
Mr. Davis. Thank you.
Mr. Slavitt. And your question is an important question because all physicians who participate in Medicare program are going to have a significant opportunity to get rewarded and get paid for providing quality medicine, which is exactly what we hear from physicians that they want. Some physicians will have the opportunity to go further, and I think the law allows those physicians to get a 5 percent bonus if they participate in these advanced payment models.
So our goal is not just to make the core program good but to create as many opportunities for physicians as possible, to move into these programs, and we can do that a number of ways. One of the important ways to do that is to simply create more models and more opportunities. We also have to make it easy for people to move back and forth if they choose to between programs, and I think that is one of the things that we are striving to achieve.
And then, as we talked about earlier with Dr. Price, we also have to look at are there ways we can take existing models and make them compliant with this new law. So we are going to work on all three of those avenues because it is a goal that for any physician that wants to move to one of these advanced APM or care coordination models that they have the opportunity to do so.
Mr. Davis. Thank you very much.
Thank you, Mr. Chairman. I yield back.
Chairman Tiberi. Former Mayor Marchant of Texas is recognized for 5 minutes.
Mr. Marchant. Thank you, Mr. Chairman.
Mr. Slavitt, does the CMS have the resources to approve and implement the new alternative payment model proposals in a timely manner?
Mr. Slavitt. Yes. Thank you.
So I believe the question is can we implement new models in a timely manner, and one of the things that we have to do -- and the answer is yes, we do. We need to, in concert with the committee that was set up by the Congress, the PTAC, we need to receive proposals from physicians because physicians can generate their own proposals for models and quality and then work with them to, as rapidly as possible, test them and put them into action.
It is one of the things that we have had the opportunity to work on over the last 6 or 7 years through the innovation center. It is something that we have gotten better and better at, and we are eager to get going with this committee to get as many models in as possible so that we can get more and more models approved. And I had a chance to speak with that committee and speak in front of that committee to try to encourage more model development.

Mr. Marchant. And there is a deadline period, so you are confident that you can get all that done by the deadline?
Mr. Slavitt. Well, fortunately, this is something that will be ongoing, so as soon as we get models in we can get them tested. But this committee, I believe, will be standing for a number of years. I am not sure if I know the exact number of years, but it will be ongoing because physicians will be able to continue to develop new models.
Mr. Marchant. So the transition in governments that is coming up wont have any affect on this process?
Mr. Slavitt. No. The staff at CMS will work with the new secretary, whoever that is, and continue moving that forward very much with that, and I think there is -- as I have heard today and as I think we continue to hear -- there is strong bipartisan commitment and a strong commitment to this program in moving this forward, so I don't see any concerns at this point.
Mr. Marchant. And just some input in my district, I hear from two different groups, and this is concerning the new program where you basically are -- let's say, a knee replacement or a hip replacement, you are basically going to fund a lump sum for that. I am hearing from seniors who think that the doctors and hospitals are going to cut corners so that they will make the most amount of profit and just hurry them through the system. And then I am hearing from the doctors and the hospitals who are afraid that they are not going to get enough money to take the kind of care of their patients that they need to take care of.
So I guess, you have created a pretty positive -- these two tensions that are working out there and could you just make a comment about that?
Mr. Slavitt. Sure. I think what you are referring to is a new type of payment approach, new for Medicare but it has been ongoing in health care for a long time, called the bundled payment.
Mr. Marchant. Yeah.
Mr. Slavitt. And really the idea behind the bundled payment is so that people -- everyone who is involved in the patient care, whether it is before they would have a surgery, the surgeon, the anesthesiologist, but also the people that take care of the patient afterwards, have an alignment to get on the same page to provide a high-quality outcome and to do it as a team.
And so it is relatively new to Medicare. We have had good experience and good feedback so far. But as with anything new, we continue to look for feedback, for data, for our experiences, and in particular, if there are beneficiaries in your district or hospitals or physicians in your district that have experience with the program, we would love to get them from you or your staff.
Mr. Marchant. Well, the group that I hear from the most is the in-home healthcare people, who feel like they are kind of at the tail end of the process and that they may be the ones -- and they feel like they are the most cost effective of all, yet they feel like at the end of that process there may be some shortchanging going on.
Mr. Slavitt. Thank you.
Mr. Marchant. Okay. Thank you.
Chairman Tiberi. Thank you.
Mr. Lewis is recognized for 5 minutes.

Mr. Lewis. Thank you very much, Mr. Chairman, for holding this hearing today.
Mr. Administrator, thank you for being with us. Thank you for all your great and good work.
Can you talk more about what people on Medicare might experience as a result of this change of payment policy, how would smaller provider groups be impacted and the doctors who need help to get up to speed.
Mr. Slavitt. Thank you.
So I think the most important thing that we have an opportunity to focus on here, is patient care and improving patient care. And I think the ways to do so this are severalfold: First is, this new legislation allows us to pay physicians more for providing higher-quality care, and the objective is to do this in a way which allows the physician to define what they believe to be the highest quality care from a menu of options and reward them for achieving those benchmarks. And I think physicians have been asking for that in one form or another for quite some time.
Secondly though, it is important to do that in a way that frees up physicians to actually practice medicine instead of just keeping score. And too many programs result in a lot of paperwork and a lot of scorekeeping and a lot of reporting, and we need to minimize that by simplifying wherever possible.
The role of small physician practices, which you also mentioned, is critical here. And as we mentioned earlier, we believe that small, solo, and solo practitioners have every opportunity to be just as successful as larger size practices, and our data suggests that that indeed happens so long as the smaller practices report. So that means we need to minimize paperwork.
We have also put in place some accommodations for smaller practices, including some technical assistance, some additional models, and ways that they can get excluded from reporting if their volumes are too low.
Mr. Lewis. Thank you.
Furthermore, Mr. Administrator, this is a very large regulation, over 900 pages. It is pretty big. It is a lot to digest, a lot to understand. If you had to tell your doctor the highlights of these changes, what would you tell her, what would your doctor need to know to maximize benefits and avoid payment cuts?
Mr. Slavitt. Great. That is a great question, and it may be one of the most important things that I can communicate today.
First of all, it is key focusing on patient care. There is nothing in here that should distract anybody from patient care, and, in fact, it will make it easier by streamlining a patchwork of programs that are already out there today into something simpler. So that is first.
Second is they will have the opportunity to select goals that they believe are right for their practice and right for their patient population, and at some point in time they will have an opportunity to do that.
Third, I think, would be that over time there will be opportunities for them to participate in more advanced models, like the kinds you asked me about earlier.
Fourth, is they don't need to really worry about reporting anything until spring of 2018, and we will make it clear what needs to be done well before then.
And then finally, the last thing, and this is more my ask of them, is to provide feedback, whether it is -- to this rule, whether it is through the medical society they belong to, the State medical society, directly to us. We really need line physicians who are practicing

medicine every day to give us their feedback on what works about this rule and what might be the unintended consequences.
Mr. Lewis. Thank you very much. And again, I appreciate your effort, your great and good work, and thank you for being willing to serve.
Mr. Slavitt. Thank you.
Mr. Lewis. Mr. Chairman, I yield back.
Chairman Tiberi. Thank you, Mr. Lewis.
Mr. Paulsen is recognized for 5 minutes.
Mr. Paulsen. Thank you, Mr. Chairman.
And Mr. Slavitt, it is great to see you here today -- welcome -- rather than on an airplane going back and forth to Minnesota.
As has already been said, you know, last year both sides took very historic action to move forward, finally get rid of the flawed Medicare payment formula based on the SGR and that wonder if we are going to fix it every 6 months or every year. And like any law, passage is just the first step, right. It is the implementation that has to be carried out and followed through and making sure it is done correctly and so that we are achieving the intended results.
I just want to thank you at the outset for working with physicians, working with patients, having that connecting dialogue with all the appropriate stakeholders, including members of the committee to making sure that we are implementing it in the correct fashion.
I do want to continue on the comment theme and just mention at the outset that it is important to know that I continue to hear from folks back in Minnesota as well that aren't in large, integrated practices, solo practices, small group practices, et cetera, that do have that concern. And as you mentioned, you want to make sure that they have every opportunity to participate. And I think they want that reassurance and we just kind of need to keep monitoring that going forward. I thank you for that.
Let me ask you this question: I have also heard from a lot of physicians and doctors in Minnesota about the meaningful-use program for electronic health records and how it doesn't do a very good job of taking into account the way physicians treat patients and use their electronic healthcare records. Is this rule the same-old, same-old, or do you make real changes in how you are going to be encouraging doctors now to actually use their electronic healthcare records?
Mr. Slavitt. Thank you, Congressman. And I would agree that our district practices some of the best medicine.
The meaningful-use program is something that we took an extremely hard look at. We took a step back, because the meaningful-use program actually is responsible for helping to make technology pervasive in medicine, and that is a very good thing. If we look back 5 or 6 years ago, most physician offices, most hospitals didn't have adequate information technology. Today, by and large, 97 percent of hospitals, 70 percent of physician practices have technology.
But as we look at how to go forward, we spend a lot of time talking to physicians and hearing exactly what you said, Congressman, which is that the meaningful-use program was focusing on making sure they were using their computers and not focusing on taking care of patients.
We also heard that physicians want their technology to be more connected. They want to be able to get information back and forth from other physicians when they refer patients

or from hospitals, and they are also frustrated that there isn't enough connectivity and the data doesn't flow as easily as it should.
And so we have been asked to focus on it, and I believe have focused on, in this rule, changing the program so it becomes much more flexible, moves the focus to the patient and away from the use of the technology, focuses on the interaction and communication, and allowing the free flow of data to move back and forth. And those are the areas that we emphasize we look forward to comments during the comment period about whether or not we have done that well.
Mr. Paulsen. Does it seem like the proposed rule, replacing meaningful use with this new category, advancing care information, right, we have all these different acronyms, but accounting for 25 percent of a physician's performance score in the first year, is that going to essentially be interoperability now for electronic healthcare information for venders, for hospitals, for all the different actors and players, physicians and other providers? Is that the intent that this information is going to be that widely shared, that readily available, not just being on the computer but actually using information?
Mr. Slavitt. Right. That is the intent. I would say everybody has a job to do in that regard. If any of us here could wave our magic wand and make the healthcare system more interoperable, I think we would do it. But this really requires vendors to share data to publish to what they call open APIs, to not practice what we talk about is data blocking, which the Congress has expressly asked that vendors not do, and physicians, to a large extent are really a victim of what the technology allows.
They all want to share data. I have not met a physician who when they refer a patient doesn't want to know what happened to that patient and get that back electronically. But it is the technology that really needs to do that job. We think in the EHR certification that just came out and in a number of the other activities, we think vendors are going to move in that direction. They need to move in that direction.
Mr. Paulsen. Thank you, Mr. Chairman. Appreciate it. I yield back.
Chairman Tiberi. Thank you, Mr. Paulsen.
Thank you, Mr. Slavitt.
One comment related to that is -- we can discuss this more -- as you develop a final rule and the performance period begins on January of 2017, vendors are going to have a limited time to reconcile with this new rule and then physicians are going to have to digest the new rule. So, you know, I hope that, again, particularly for the small group rural markets, I hope that you will work with us to make sure that that implementation is done smoothly.
And related to that, I don't know if you think you have some authority in this area, so the gap of time between performance period and then the payment here for physicians is 2 years, yet the clinician reporting period is a shorter period of time. Do you think CMS has the ability, the rulemaking, the authority to change that a little bit?
Mr. Slavitt. Yep. So one of the things that we do see comment on are the proposed measurement periods and payment periods. What I will say is a couple things: One is, we have two feedback periods built in so that -- one in the middle of 2017 and one in the middle of 2018, to provide information back to physicians. So there is a more current feedback loop.
The second thing I would say is because we have focused so much on reducing burden and reducing the number of measures and so forth, that is -- we have had some feedback

that people want to make sure that that starts as early as possible. We have had other feedback, of course, which tells us make sure we have enough time, make sure we have enough time to do the things we need to do, make sure we don't get penalized unnecessarily because we didn't have enough time.

And to your earlier question, Mr. Chairman, if people will begin on the older technology and move to the newer technology, they will not get penalized for that. So we are making those accommodations. But of course, the purpose of the comment period is for people to tell us what are the things we missed, what are the things that could have an impact on someone's practice or on their patients that we didn't think of.

And that is one of the reasons why, if there is an important message today to get out, it is to please engage in the rule and give us the feedback that we need to hear.

Chairman Tiberi. Well, I can't thank you enough for coming today. As you can tell, in a bipartisan way, members have a lot of interest in this and not just at the subcommittee level but the committee as a whole, as well as the Congress.

And we really appreciate you taking the time and look forward to working with you and your team as you continue to develop this and ultimately put it into process the way that we all intended it to be. And appreciate the fact that you were so kind yesterday as well. Look forward to working with you. Hopefully we have treated you nice enough that you will come back, as we have this bipartisan concern about the way this unfolds.

So as a reminder, any member wishing to submit a question for the record will have 14 days to do so. If any members submit questions after the hearing, I ask that the witnesses respond in writing in a timely manner.

Chairman Tiberi. With that, again, thank you and this committee is adjourned.

[Whereupon, at 3:36 p.m., the subcommittee was adjourned.]

Public Submission For The Record

Member Questions For The Record