

**Hearing on Implementation of
MACRA's Physician Payment Policies**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS
SECOND SESSION

MARCH 21, 2018

Serial No. 115-HL04

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Hearing on Implementation of MACRA's Physician Payment Policies

U.S. House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C

WITNESSES

Demetrios L. Kouzoukas

Principal Deputy Administrator, Centers for Medicare and Medicaid Services, joined by
Dr. Kate Goodrich, Chief Medical Officer, Centers for Medicare and Medicaid Services
Witness Statement



WAYS AND MEANS

CHAIRMAN KEVIN BRADY

Chairman Roskam Announces Hearing on Implementation of MACRA's Physician Payment Policies

Committee on Ways and Means Subcommittee on Health Chairman Peter Roskam (R-IL) announced today that the Subcommittee will hold a hearing on the "Implementation of MACRA's Physician Payment Policies." The hearing will focus on the Administration's implementation strategy for the physician payment policies from the Medicare Access and CHIP Reauthorization Act (MACRA). The witnesses will speak to both the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs), and the Administration's priorities in achieving greater value and outcomes in Medicare through these programs. **The hearing will take place on Wednesday, March 21, 2018 in 1100 Longworth House Office Building, beginning at 2:00 PM.**

In view of the limited time to hear witnesses, oral testimony at this hearing will be from the invited witness only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, April 4, 2018**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve

the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days' notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at <http://www.waysandmeans.house.gov/>

IMPLEMENTATION OF MACRA'S PHYSICIAN PAYMENT POLICIES

Wednesday, March 21, 2018

House of Representatives,

Subcommittee on Health,

Committee on Ways and Means,

Washington, D.C.

The subcommittee met, pursuant to call, at 2:00 p.m., in Room 1100, Longworth House Office Building, Hon. Peter J. Roskam [chairman of the subcommittee] presiding.

Chairman Roskam. The subcommittee will come to order.

Good afternoon, everyone. Nice to know that you all have a high tolerance for snow days. Pretty impressive all the way around.

Before we begin, I would like to echo the observation and express our shared sorrow that Chairman Brady did this morning in the full committee hearing and offer our condolences to the family of our colleague, Louise Slaughter.

She faithfully represented her New York constituents for more than 30 years and was quite a force on the Rules Committee. Many of us testified before that committee, and she was no one to underestimate.

Let's get started with this hearing.

For those who have been around for a little while, it wasn't too long ago that we were still living by an all too familiar deadline in healthcare, the annual headache and complete hassle that was known as the doc fix. There was nobody who was happy about this, and there was nobody who was satisfied with this. It was just universally loathed.

The sustainable growth rate, or SGR, was a failing payment model that was supposed to control costs in Medicare, but in turn, created payment uncertainty for doctors in Medicare that Congress acted to avert 17 times over the course of 15 years.

Two years ago, this committee came together in a bipartisan fashion, working with stakeholders and CMS, to craft the Medicare Access and CHIP Reauthorization Act, or MACRA, because we didn't have enough acronyms. By consolidating the separate reporting requirements and rewarding higher quality care, we have begun to move toward a system that fully integrates value-based care and places the proper incentives on high-quality care.

That is not to say that the law is perfect. And while in its intent the success of MACRA lines up with the success of the Medicare program and the move to value over volume, today we will hear from the Centers for Medicare & Medicaid Services, or CMS, on how the implementation of that intent is going, and whether or not we have learned lessons from the past 2 years as it relates to MACRA.

Several technical fixes to MACRA were included in the Bipartisan Budget Act that we passed in February. These changes grant greater flexibility and discretion to CMS as they continue to implement this new program to ensure that there are no attainable goals that will prevent our doctors from succeeding if what they are doing is the right thing and to avoid any cliffs that will create a loss of faith in this blossoming new payment program.

We also included a fix that would expand the responsiveness of the Physician Technical Advisory Committee to stakeholders who have submitted ideas for alternative payment methods. APMs are foundational to the intent of MACRA that providers work together to create new, more efficient payment models that would result in better outcomes for patients.

So I hope that the PTAC, CMS, and the Innovation Center all are working together to maximize the amount of models available to our doctors and Medicare. And we are holding this hearing as a continuation of our commitment to oversee proper implementation. That is the scope of this hearing: to discuss the implementation of MACRA and to understand its role in the move to higher value, more patient-centered care for our seniors. So I hope that on a bipartisan basis we are going to explore these issues.

Our role as Congress is to provide oversight, and, in conjunction with CMS, continue to provide education on a law that is working for providers in Medicare. And as we explored at the last MACRA hearing, the question is: is CMS continuing to make sure that our small and individual practice providers have the opportunity to succeed under this program?

We hope to continue to hear from stakeholders as we move forward beyond this hearing and to work with CMS in implementing this law correctly, and I think we can do some good work.

With that, I will now yield to the ranking member for the purposes of his opening statement.

Mr. Levin.

Mr. Levin. Thank you very much, Mr. Chairman. And all of us on this side join you in remembering Louise Slaughter.

Anybody who had the privilege, if you want to call it that, of appearing before the Rules Committee noted her tenacity and her patience laced with impatience. She was a determined battler, and her sudden passing has left us all poorer.

Thank you, Mr. Chairman, for holding this hearing.

And thank you, Mr. Kouzoukas and Dr. Goodrich, for joining us.

Nearly 3 years ago, President Obama signed into law MACRA, the Medicare Access and CHIP Reauthorization Act. This bipartisan legislation put an end to the recurring threat of draconian Medicare cuts under the flawed sustainable growth rate formula.

By creating a new Quality Payment Program and alternative payment models that reward physicians and other providers that coordinate care and achieve better outcomes, MACRA took us several steps forward in our effort to make Medicare an increasingly value-based program.

I just want to add to my remarks how this was an important part of the ACA, as we worked on it, to really move away from a fee-for-service to a value-based program. So we look forward to the hearing today to see what progress has been made.

However, as useful as today's meeting is in reviewing MACRA, we must recognize that we are not holding this hearing in a vacuum. The actions of the Republican majority and this administration have caused upheaval in the healthcare system that has undermined many of the goals we hope to achieve through MACRA. Regrettably, throughout all of this chaos, this subcommittee has not been sufficiently active, holding just three hearings prior to today.

The President has consistently worked to undermine and sabotage key aspects of ACA through administrative actions. These include ending cost-sharing reduction subsidies, slashing funding for navigator groups, in the area I come from slashed by 90 percent, and outreach programs, and, most recently, expanding the reach of short-term policies that can evade important patient protections.

These and other actions have left the insurance markets in chaos or near chaos and resulted in major premium increases in many parts of the country. Yet, despite the urging of us Ways and Means Democrats, we have not held any hearings on any of these issues. As we move forward, we must no longer ignore these harmful proposals.

Furthermore, we must acknowledge that the President's budget would devastate access to care for millions of Americans. His budget cuts more than \$1.4 trillion from Medicaid by switching to per capita caps and block grants while ending the ACA's Medicaid expansion. It also slashes \$532 billion from Medicare through, among other cuts, a radical restructuring of the graduate medical education program and devastating cuts to home health agencies and nursing facilities that serve the most vulnerable beneficiaries.

When it comes to value-based payment, the approach of the administration has not reflected the bipartisan -- I emphasize that -- commitment that Congress showed in passing MACRA. Instead, it is more about conservative ideology and commonsense innovation.

By massively scaling back value-based payment efforts begun during the Obama administration and hinting at a shift towards premium support and privatization experiments, the administration has left many seniors worried about what lies ahead for Medicare.

Mr. Chairman, MACRA was a truly bipartisan effort, and we share a goal of ensuring that it is ultimately a success. Today's hearing reflects that bipartisan commitment; however, we must not ignore the broader developments that have undermined the spirit and threatened to greatly overshadow the improvements made by MACRA.

Thank you, Mr. Chairman.

Chairman Roskam. Thank you.

I am pleased to introduce today's witnesses, as we are fortunate to have them both. They have got a broad background, and they know what they are talking about.

Demetrios Kouzoukas -- from Chicagoland, I might say, originally -- is the Principal Deputy Administrator at the Centers for Medicare & Medicaid Services and the Director of the Center for Medicare. And he is joined at the table by Dr. Kate Goodrich, the Chief Medical Officer at CMS and also the Director for the Center for Clinical Standards and Quality.

We are really pleased you are here.

Mr. Kouzoukas, why don't you tell us what you know? You have 5 minutes, and then we can inquire. Thank you.

**STATEMENT OF DEMETRIOS L. KOUZOUKAS, PRINCIPAL
DEPUTY ADMINISTRATOR, CENTERS FOR MEDICARE &
MEDICAID SERVICES, JOINED BY DR. KATE GOODRICH, CHIEF
MEDICAL OFFICER, CENTERS FOR MEDICARE & MEDICAID
SERVICES**

Mr. Kouzoukas. Thank you, Mr. Chairman.

Chairman Roskam, Ranking Member Levin, and members of the subcommittee, thank you very much for the invitation and the opportunity to come here today and discuss the work we are doing at CMS, the Centers for Medicare & Medicaid Services, to catalyze a transformation in our healthcare system, from one that pays for sickness and procedures to one that pays for value and health.

When I talk about our work in this regard, people ask me sometimes, "What does value mean?" After all, it is an ambiguous term. And I want to tell you today that value means putting patients in the driver's seat, ensuring that patients are in a position to make their own determinations about the care they receive, in consultation with their providers and with the support of their families and communities.

We know that many problems in our healthcare system come from the fact that it has been assembled in Washington rather than assembled by patients. And so what I would like to talk to you about today is the course we have charted to remedy those concerns and challenges.

Secretary Azar has outlined four areas of emphasis that we undertake in this fundamental reorganization of our healthcare system.

First, give consumers greater control over their health information through interoperable and accessible healthcare information technology -- their medical records. Allow them to get their information in their hands so that they can move around and be consumers in a healthcare market.

Second, encourage transparency from payers and providers so that patients can make choices based on price and quality, as they would in any other market.

Third, leverage the power of patients and put resources behind them by using the authorities at CMMI and otherwise in Medicare and Medicaid to help drive value and quality through the entire system.

Last, reduce government burdens that impede this transformation by ensuring that patients can spend more time talking to their physicians and facing them in one-on-one conversations, rather than looking at the back of their lab coat.

These are the same principles that guide our implementation of Congress' vision for Medicare clinician payment through MACRA.

As Principal Deputy Administer and Director of the Center for Medicare, I lead a dedicated team. It is a real privilege to work with so many civil servants who have worked hard to achieve this vision in many different forms.

I am pleased, in particular, to be joined today by CMS' Chief Medical Officer and Director of the Center for Clinical Standards & Quality, Dr. Kate Goodrich. Kate has been on the front lines of our hard work to drive value and quality and remove government burdens that impede the transformation I discussed.

In thinking back about this conversation, this dialogue we are going to have with the committee today, I started to think, in particular, about my first interactions with the healthcare system, at least the ones that I can remember, and I thought back to the times where my sister and I helped take care of my father.

My father suffered through a number of chronic diseases through much of his adult life, and we spent many times working with him and other providers as a whole family as he went from doctor to doctor and hospital to hospital to

provide that support in our own family for someone who was sick and wanted to get healthier.

And I have to say that in those experiences, those encounters, I always wondered, “Why is it so confusing? Why don't these doctors talk to each other? Why is it so hard to get copies of these medical records? Why can't we ensure that we have an opportunity to make decisions about the care that is right for us, rather than have the feeling that so much is being done to us?”

These experiences fueled my interest and passion in healthcare, and they shape the perspective that I bring to CMS and the important work that we are doing.

As I got more opportunities to participate in healthcare policymaking, I saw that too often the problem is that we have created a healthcare system that has erected fractured silos over the care that providers give and the opportunity that patients have to drive their choices.

Providers are driven largely by empathy, a desire to help the people standing in front of them who aren't healthy and who need help, and we have made it more difficult for them to channel that empathy towards helping that whole patient.

The work that we are doing is about transforming that, about giving providers an opportunity to put themselves at the disposal of their patients and work with them, support them, as they experience a transformational shift to patient-driven healthcare.

And MACRA is part of that. We are implementing MACRA in a way that is consistent with that general philosophy. Last year, this administration focused our attention on making MACRA work, in particular, for individual clinicians, as well as small and rural practice groups. We provided additional flexibility to small groups, increased the threshold for participation in one aspect of MACRA, and made it easier for clinicians to join together in what are called virtual groups.

We are grateful for Congress' continued leadership in this area, particularly the additional flexibilities that were granted in the recently enacted Bipartisan Budget Act.

We are working every day to make sure that healthcare decisions are made by patients in consultation with their healthcare providers and with the support of their families and communities.

CMS will continue to drive toward this vision of what value-based healthcare means. In so doing, I am certain we will achieve the vision of a healthcare system that is not assembled in Washington, but assembled by each patient.

STATEMENT OF

**DEMETRIOS KOUZOUKAS,
PRINCIPAL DEPUTY ADMINISTRATOR, AND
DIRECTOR
CENTER FOR MEDICARE
CENTERS FOR MEDICARE & MEDICAID SERVICES
AND
KATE GOODRICH, M.D.
DIRECTOR,
CENTER FOR CLINICAL STANDARDS AND QUALITY, AND
CHIEF MEDICAL OFFICER
CENTERS FOR MEDICARE & MEDICAID SERVICES**

ON

THE IMPLEMENTATION OF MACRA'S PHYSICIAN PAYMENT POLICIES

BEFORE THE

**U. S. HOUSE COMMITTEE ON WAYS & MEANS,
SUBCOMMITTEE ON HEALTH**

MARCH 21, 2018

**U. S. House Committee on Ways & Means,
Subcommittee on Health
“The Implementation of MACRA’s Physician Payment Policies”
March 21, 2018**

Chairman Roskam, Ranking Member Levin, and members of the Subcommittee, thank you for the invitation and the opportunity to discuss the Centers for Medicare & Medicaid Services’ (CMS’s) work to transform our healthcare system from one that pays for procedures and sickness to one that pays for better value and improved outcomes by empowering patients and reducing clinician burden. These principles are our key focus as we work to implement the Congress’s vision for Medicare clinician payment in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The goal of a value-based transformation of our entire healthcare system has been a longstanding one but often this transformation has been a frustrating process for clinicians. We have not yet fully realized the promise of MACRA. Too few physicians and clinicians are participating in alternative payment models, and far too many clinicians found the law’s reporting requirements too burdensome. Nevertheless, we cannot turn back to an unsustainable system that pays for procedures rather than value. We must move forward on four areas of emphasis: giving consumers greater control over health information through interoperable and accessible health information technology; encouraging transparency from payers and providers; using experimental models in Medicare and Medicaid to help patients drive value and quality throughout the entire system; and removing government burdens that impede this transformation.

We know this transformation -- and MACRA in particular -- is a big change for clinicians and their patients, but CMS is committed to promoting market based competition, interoperability, and transparency to make sure that patients are in the driver’s seat, making their own determinations about the value and quality of the care they receive. We want to support patients by using data driven insights, increasingly aligned and meaningful quality measures, and innovative technology. CMS is working hard to evaluate and streamline regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the patient experience by allowing their healthcare providers to spend more time with them. CMS has launched the

“Patients over Paperwork” initiative¹, which is consistent with President Trump’s Executive Order, which recognizes the importance of managing costs associated with Federal regulations. Through “Patients over Paperwork,” CMS established an internal process to evaluate and streamline regulations with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience. In carrying out this internal process, CMS is removing regulatory obstacles that get in the way of clinicians spending time with patients.

One area that clinicians have told us that we can offer relief is around how they report quality and other measures to us at CMS. Far too many clinicians have also told us they feel these measures do not accurately reflect their interactions with their patients nor do they provide substantive feedback. Until we get to a smaller set of more impactful measures that assess outcomes rather than processes, the burden associated with reporting measures will run the risk of outweighing their intended purpose.

In response to these concerns and feedback from patients and clinicians, CMS developed the Meaningful Measures initiative² to identify the highest priorities for quality measurement and improvement. It involves only assessing those core issues that are the most critical to providing high-quality care and improving individual outcomes. The Meaningful Measure Areas serve as the connectors between CMS goals under development and individual measures/initiatives that demonstrate how high quality outcomes for our beneficiaries are being achieved. To the extent that legislation requires us to measure quality, we want to pick measures that reflect patients’ choices and outcomes instead of process and other “check-the-box” measures that offer no real value to the patient. We’re committed to measuring quality without increasing burden. To decrease the reporting burden for clinicians, we will utilize measures drawing on data from claims, registries, or electronic health records where possible. We continue to seek feedback from clinicians on how we can simplify documentation requirements and other paperwork that

¹ For more information: <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html>

² <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html>

can get between a physician and their patients, including creating a virtual “suggestion box” that allows healthcare providers to share their ideas.³

CMS is bringing all of these principles and approaches together as we work to implement Congress’ vision of a fundamental reorientation of how Medicare pays for clinician services. We want to create a true competitive playing field where value is rewarded and the patient makes the decisions. This transformation to a competitive, value-based marketplace will require innovative ideas, approaches, and solutions from outside of Washington.

The Quality Payment Program (QPP)

With the leadership of this Committee and others in Congress, MACRA repealed the flawed Sustainable Growth Rate (SGR) formula, which put clinicians at the risk of cuts in Medicare payments, and replaced it with a new program that CMS calls the Quality Payment Program. CMS appreciates Congress’ continued leadership and engagement as we implement the Quality Payment Program, particularly the additional flexibilities granted as a part of the recently enacted Bipartisan Budget Act of 2018⁴ (PL 115-123). These flexibilities will ensure CMS is able to continue our implementation work by minimizing the burden on clinicians.

Like any new program requiring significant changes to the way clinicians are incentivized within Medicare, the Quality Payment Program has faced significant barriers to achieving the well-intended goals it was designed to accomplish. Congress specified in MACRA that most clinicians who furnish items and services paid under Medicare Part B would be subject to payment incentives under one of two paths: the Merit-based Incentive Payment System (MIPS) or the Advanced Alternative Payment Models (Advanced APMs). Clinicians face unique challenges under each path, whether they work alone or in groups to meet the MIPS requirements and earn a payment adjustment or whether they take on financial risk in Advanced APMs to potentially earn an APM incentive payment and be excluded from the MIPS reporting requirements and payment adjustment.

³ ReducingProviderBurden@cms.hhs.gov.

⁴ <https://www.congress.gov/bill/115th-congress/house-bill/1892/>

The President's FY 2019 budget⁵ included a proposal to further simplify and reduce the reporting burden under the MIPS for physicians and other clinicians by proposing to adopt broader claims and beneficiary survey calculated measures that assess clinician performance in the quality performance and cost categories at the group-level only. This proposal would use payment adjustments under the current statute and would retain the \$500 million in annual additional positive payment adjustments for top performers.

Implementing the Merit-based Incentive Payment System (MIPS)

The principal way that MIPS measures quality of care is through a set of quality measures from which MIPS eligible clinicians can select. Congress created four statutory pillars of the MIPS incentive structure: the performance categories of Quality; Improvement Activities; Advancing Care Information (based on the Medicare Electronic Health Record Incentive Program); and Cost. Clinicians will earn a payment adjustment based on information they submit or CMS determines from claims, demonstrating that they provided high quality, efficient care.

MIPS began with the first performance period in 2017 (Year One), during which clinicians were able to “pick their pace” and choose when and which performance data they submit to CMS. In the first year of the program, the cost category was not included in the final score. Depending on what Year One data a clinician submits, their 2019 Medicare payments could be adjusted. For example, if a clinician reports that they have completed one quality measure or one improvement activity, they will be able to avoid a downward payment adjustment. If a clinician submits partial Year One data (at least 90 days) they can earn a neutral or positive payment adjustment. Those clinicians who submit a full year of Year One data may earn a higher positive payment adjustment. Those who do not submit any Year One data will receive a negative four percent payment adjustment.

CMS launched a new data submission system for clinicians in MIPS, and eligible clinicians are now submitting their Year One data. The new data submission system is an improvement from the systems under the former Medicare quality programs, which required clinicians to submit

⁵ <https://www.whitehouse.gov/wp-content/uploads/2018/02/budget-fy2019.pdf>

data on multiple websites. The new data submission system makes it easier for clinicians to meet the Quality Payment Program's reporting requirements and spend more time treating patients instead of filling out paperwork. For example, we are providing clinicians multiple data submission options, including existing data registries, which they already utilize. Eligible clinicians can also submit data using a Health IT Vendor, which extracts data from certified electronic health record technology; however, in the spirit of flexibility and burden reduction, eligible clinicians can also choose to manually upload their data into the submission system. As data is entered into the system, eligible clinicians will be able to see real-time initial scoring within each of the MIPS performance categories based on their submissions. Once the submission period closes, we will calculate payment adjustments based on the clinician's last submission or submission update.

CMS recognizes the Quality Payment Program is a big change. Calendar Year 2018 marks the second performance period (Year Two), and CMS is offering additional flexibility to clinicians to help meet the Quality Payment Program's reporting requirements. Consistent with this Administration's goal of reducing clinician burden and putting patients first, in the Year Two final rule with comment period⁶, we slowed the ramp-up of the Quality Payment Program by establishing special policies for MIPS aimed at encouraging successful participation in the program by reducing burden, and reducing the number of clinicians required to participate. We have also implemented additional hardship exceptions, focused on flexibility for small and rural practices, and provided a scoring adjustment to account for clinicians that treat complex patients. Our hope is for the program to evolve to the point where all the clinical activities captured in MIPS across the four performance categories reflect the goal of promoting market based competition, interoperability, and transparency by making sure that patients are in the driver's seat.

Additionally, concurrent with the 2018 rulemaking for the second year of the program, CMS also published an interim final rule with comment period to establish an automatic extreme and uncontrollable circumstance policy for the 2017 MIPS performance period. This policy

⁶<https://www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-program-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme>

recognizes that recent hurricanes (Harvey, Irma, and Maria) and other natural disasters can effectively impede a MIPS eligible clinician's ability to participate in MIPS and relieves reporting requirements for clinicians who are located in affected areas.

CMS will continue its gradual and measured approach to implementation of MIPS, following the provisions of the recently enacted Bipartisan Budget Act of 2018, where Congress granted additional flexibilities. These provisions give CMS additional flexibility in determining the MIPS Performance Threshold for three additional years, provide CMS flexibility in determining weight for the MIPS cost performance category, and restrict applicability of the MIPS payment adjustments to covered professional services under the Physician Fee Schedule. As we continue to refine and improve the Quality Payment Program and look to reduce clinician burden, our focus is on integrating this new program into clinicians' existing workflows to ensure smooth implementation and minimizing any disruption to patient care.

Encouraging Participation In Advanced Alternative Payment Models (Advanced APMs)

In addition to carefully and deliberately implementing the new requirements of the Quality Payment Program for MIPS, CMS has focused on developing Advanced APMs. Congress established the criteria for "Advanced APMs." Clinicians with sufficient participation in Advanced APMs during a performance year receive a five percent APM incentive payment for payment years through 2024. It is our belief that MIPS builds the capacity of eligible clinicians across the four pillars of MIPS to prepare them for participation in APMs in later years of the Quality Payment Program.

Advanced APMs are those that require participants to bear a certain amount of financial risk, base payments for clinicians' services on MIPS-comparable quality measures, and require participants to use certified electronic health record technology. Unfortunately, the process to develop new models, including those that are Advanced APMs is extensive and lengthy. This has resulted in too few Advanced APMs. CMS is testing or has announced for future testing only ten Advanced APMs and too few of those include specialty clinicians. In the QPP Year 2 Final Rule, CMS estimated that 185,000 to 250,000 will be eligible to receive the five percent APM incentive payment and be exempt from MIPS reporting requirements, based on the 2018

performance period. If we want to realize the full promise of MACRA and Advanced APMs we need to do more.

CMS is working to develop new Advanced APMs and providing resources and assistance to help clinicians wishing to participate in Advanced APMs, so they have the opportunity to earn the APM incentive payment each year and be excluded from the MIPS reporting requirements and payment adjustment. We want to work to provide as much clarity and flexibility as possible to achieve the goals of improving health outcomes, promoting efficiency, minimizing the burden of participation, and providing fairness and transparency in operations.

In addition to encouraging clinician participation in Advanced APMs with Medicare, Congress also created the All-Payer Combination Option that offers clinicians another way to earn the five percent APM incentive payment (and exclusion from the MIPS reporting requirements and payment adjustment) based on combined participation in both Advanced APMs and Other Payer Advanced APMs, which are alternative payment arrangements that meet certain criteria within Medicaid, Medicare Health Plans, payers in CMS Multi-Payer Models⁷, and other commercial payers. In the 2018 rulemaking for the Quality Payment Program, we established policies to implement the All-Payer Combination Option in 2019. Where possible, we have created additional flexibilities and alternatives to allow clinicians to be successful under the All-Payer Combination Option.

Within CMS, the Center for Medicare and Medicaid Innovation (Innovation Center) bears primary responsibility for developing Advanced APMs. The Innovation Center's statutory authority allows CMS to test innovative payment and service delivery models expected to reduce expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries.

⁷ CMS Multi-Payer Models means an Advanced APM that CMS determines, per the terms of the Advanced APM, has at least one other payer arrangement that is designed to align with the terms of that Advanced APM. An example of a CMS Multi-Payer Model is the Comprehensive Primary Care Plus Model.

CMS has a responsibility to make sure the models we design for testing are data driven, include appropriate beneficiary and program integrity protections, and meet the statutory requirements for the testing of models.

Our existing partnerships with healthcare providers, clinicians, states, payers and stakeholders have generated important value and lessons and CMS is setting a new direction for the Innovation Center. That is why, in September 2017, CMS released a Request for Information⁸ (RFI) seeking public feedback on ways to promote patient-driven care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes. The RFI asked for input on ways to increase opportunities for eligible clinicians to participate in Advanced APMs and meet eligibility requirements to receive the APM incentive payment. For example, we asked for feedback on how CMS can be more responsive to eligible clinicians and their patients while expediting the process for clinicians that want to participate in an Advanced APM. We also asked for guidance from stakeholders on ways to capture appropriate data to drive the design of innovative payment models and strategies to incentivize eligible clinicians to participate in Advanced APMs.

We are grateful for the comments and thoughtful ideas that we received in response to the RFI. Overall, through the close of the comment period in November, CMS received approximately 1000 submissions. We continue to review these submissions, and they will be an integral source of information as CMS moves forward with our agency-wide efforts to promote innovation, including through the creation of additional Advanced APMs that will improve the patient-provider experience. However, our engagement with stakeholders has not ended with this RFI and we look forward to continuing to working with all stakeholders to make sure we're delivering results and putting the patient in the driver's seat.

⁸ <https://innovation.cms.gov/Files/x/newdirection-rfi.pdf>

Facilitating the Development of New APMs

Although CMS has taken steps to gather and incorporate ideas regarding Advanced APMs, we know we can do better. Depending on the model, APMs generally take the Innovation Center 18 months to design and launch, and we have heard from stakeholders that the current process for announcing new models that would qualify as Advanced APMs is too lengthy. A model's lifecycle includes model design, testing, evaluation, and expansion, if the statutory requirements for expansion are met. For example, once the Innovation Center identifies innovative payment or service delivery models that show promise, the Innovation Center has to determine the appropriate payment methodology and update CMS systems, identify the appropriate performance measures and the means to collect them, consider how to engage beneficiaries, and identify technical assistance or learning opportunities that participants might need to implement their participation in the model. We may use additional Requests for Information and listening sessions to allow the public and stakeholders to help us hone ideas into testable models. Due to the time needed for these activities, only ten APMs currently qualify as Advanced APMs⁹, and many of these are not aimed at specialists.

CMS' portfolio of APMs currently includes the following ten models and programs that are considered Advanced APMs: the Next Generation ACO Model, the Comprehensive End Stage Renal Disease Care Model (two-sided risk track), the Oncology Care Model (two-sided risk track), the Comprehensive Care for Joint Replacement Model (Track 1-CEHRT), the Comprehensive Primary Care Plus Model, the Medicare ACO Track 1+ Model, the Vermont Medicare ACO Initiative¹⁰, the Medicare Shared Savings Program Track Two, the Medicare Shared Savings Program Track Three, and the recently announced Bundled Payments for Care Improvement Advanced Model (BPCI Advanced), which will be an Advanced APM in 2019. In addition, we are exploring options to develop a demonstration project to test the effects of expanding incentives for eligible clinicians to participate in innovative alternative payment

⁹ <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Comprehensive-List-of-APMs.pdf>

Tracks 2 and 3 of the Medicare Shared Savings Program are Advanced APMs. The Medicare Shared Savings Program is a national program established in statute and is not tested by the Innovation Center.

¹⁰ Vermont ACOs will be participating in an Advanced APM during 2018 through their participation in a version of the Next Generation ACO Model. We anticipate the Vermont Medicare ACO Initiative will separately be an Advanced APM beginning in 2019.

arrangements under Medicare Advantage. We believe this is especially important for eligible clinicians who do not participate in Advanced APMs under fee-for-service Medicare.

We expect that the number of eligible clinicians choosing to participate in Advanced APMs will grow over time, and we are working hard to facilitate this growth by developing more models. We are also examining ways to increase the availability of specialty physician models to engage specialty physicians, especially for independent physician practices.

We are also working to improve model operations once testing begins and to more quickly evaluate results from models. Currently, once a model test begins, model participants often find that the first year of a model test is dedicated to becoming familiar with the model requirements and adapting how to implement them in the most effective way for the particular hospital, state, ACO, or other model participant. In addition, participant claims or state data are usually not available to CMS until several months or more after the services are provided. These issues can lead to a delay in the evaluator's ability to identify statistically significant findings and to determine which models meet the statutory requirements for expansion. The goal of the Innovation Center is to test models that meet the statutory requirement for expansion. Models may only be expanded if the CMS Chief Actuary certifies that the expansion would reduce or not result in any increase in net program spending and if the Secretary determines that the expansion is expected to either reduce program spending without reducing the quality of care or improve the quality of patient care without increasing spending and that such expansion would not deny or limit the coverage or provision of benefits.

In addition, it is possible that the complexity of certain models might contribute to consolidation within the healthcare system, leading to fewer choices for patients. But, strengthening the healthcare system will require healthcare providers to compete for patients in a free and dynamic market. We seek to test models that promote competition, based on quality, outcomes, and costs.

We continue to consider ways to further promote the goals of promoting market based competition, interoperability, and transparency by making sure that patients are in the driver's seat, making their own determinations about the value and quality of the care they receive. The President's FY 2019 Budget also proposes to eliminate arbitrary thresholds and other burdens to

encourage participation in Advanced APMs. This proposal would modify how the five percent APM incentive payment is determined in order to better reward clinicians who participate in Advanced APMs. Instead of receiving a five percent incentive payment on all Physician Fee Schedule payments if they meet or exceed the payment or patient thresholds as under current law and regulations, clinicians would receive a five percent APM incentive payment on Physician Fee Schedule revenues received through the Advanced APMs in which they participate. This change directly rewards clinicians along a continuum based on their level of participation in Advanced APMs, without subjecting clinicians to arbitrary participation threshold levels. We believe this change will encourage more clinicians to participate in Advanced APMs to the benefit of their patients.

Working with Stakeholders

CMS welcomes innovation, and we encourage anyone with a promising idea to submit it to the Innovation Center for consideration. We have an Alternative Payment Model Design Toolkit¹¹ available through our website, which provides a detailed and comprehensive set of resources to help design a proposed APM. For example, it lays out how the Innovation Center assesses ideas for new models, including descriptions of model design and evaluability factors, and includes instructions for submitting an idea through the Innovation Center website.

Physician-Focused Payment Model Technical Advisory Committee (PTAC)

Another important source for new, innovative APMs is the Physician-Focused Payment Model Technical Advisory Committee (PTAC). MACRA established the PTAC to review and assess stakeholder proposals for physician-focused payment models. The Secretary established criteria for physician-focused payment models, which include categories to promote payment incentives for higher-value care; to address care delivery improvements that promote better care coordination, protect patient safety, and encourage patient engagement; and to address information enhancements that improve the availability of information to guide decision-making. PTAC uses these criteria in reviewing these proposals and providing comments and recommendations to the Secretary. We believe that proposals submitted to the PTAC could fill

¹¹ <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Alternative-Payment-Model-APM-Design-Toolkit.pdf>

gaps in our current portfolio and ensure that clinicians are able to choose between several physician-focused payment models to find the right one for their practice. So far, the PTAC has submitted comments and recommendations to the Secretary on several proposals, and the Secretary's responses can be found on CMS's website.¹²

Health Care Payment Learning and Action Network (LAN)

The Health Care Payment Learning and Action Network (LAN) was launched to bring together stakeholders in the public and private sector to accelerate adoption of value-based payments and APMs. More than 4,800 patients, insurers, providers, states, consumer groups, employers, and other partners have participated in the LAN and over 50 organizations have made commitments to payment transformation. The mission of the LAN is to accelerate the healthcare system's transition to APMs by combining the innovation, power, and reach of the public and private sectors.

Moving Forward

As the Quality Payment Program moves through its second year, we want to ensure that there is meaningful measurement of value and quality, and that clinicians are not just being forced to check boxes. We want to make sure we are promoting better patient outcomes, improving coordination of care for patients, and supporting a simplified pathway to participation in MIPS and Advanced APMs.

Healthcare decisions should be made by those on the front lines – the patients, with healthcare providers and families of those directly involved with the care. CMS will continue to use the Quality Payment Program to promote greater flexibility and patient driven care. Our goal is to use the tools Congress gave us to allow clinicians to focus on patients over paperwork, and we are doing so by listening to innovators who know how to engineer a more efficient, market-driven healthcare system. Changes of this magnitude and complexity certainly pose challenges, and we remain committed to listening and engaging with clinicians and patients to hear what is working and how we can best fix what is not working. We know that we do not have all the answers in Washington and we look forward to continuing our work with this Committee,

¹² <https://innovation.cms.gov/initiatives/pfpms/>

members of Congress, clinicians, patients, entrepreneurs, and other stakeholders in order to find innovative ways to reduce provider burden, improve patient outcomes, curb rising costs, and empower patients.

Chairman Roskam. Thank you, Mr. Kouzoukas.

I will now recognize Mr. Johnson to inquire.

Mr. Johnson. Thank you, Mr. Chairman.

Mr. Kouzoukas, welcome.

Back in 2015, then President Obama signed legislation, which I championed with Representative Doggett, to end the use of all Social Security numbers on Medicare cards as part of the Medicare Access and CHIP Reauthorization Act.

Ending the use of Social Security numbers on these cards is vitally important to protect our seniors and other Medicare beneficiaries from identity theft, as well as to prevent fraud and abuse.

Now, it is my understanding Medicare will issue new cards next month and replace all cards by April 2019.

Mr. Kouzoukas, is that still true? Just yes or no.

Mr. Kouzoukas. Yes.

Mr. Johnson. Thank you.

Is CMS still on track, yes or no?

Mr. Kouzoukas. Yes.

Mr. Johnson. And can you tell me how Medicare is getting the word out to seniors about the new Medicare cards?

Mr. Kouzoukas. Thank you, Mr. Johnson.

First of all, let me thank you for your leadership on this issue, not only in ensuring that the legislation was passed to protect seniors, but also in providing the resources that were necessary for CMS to implement this important initiative.

Mr. Johnson. Thank you.

Mr. Kouzoukas. We have been grateful for the opportunity to interact with seniors and prepare them for this transition. After all, identity theft is an issue

of concern to everyone in today's world, and these new steps will put us in a better position to help Medicare beneficiaries not be put in a vulnerable situation.

We are working very diligently to ensure that we roll this out on a timeframe that Congress envisioned. And, in particular, one of the things we are most sensitive to is the right timing of that message.

What we have found is that seniors are very concerned about their privacy. They are very concerned about how they access the Medicare program. And so it is particularly important, as we engage with them, that we give them information at the time that is most helpful and useful to them about what is coming, and that we work with them as they have questions, and that we also work diligently on the provider side so that they are in a position to help answer questions or experience changes in the system.

And so the steps that we are taking largely involve a lot of planning and internal deliberation over exactly how to communicate when and what and how, with a careful sensitivity towards the needs of this population. It is not like communicating with other kinds of people that are in a general marketplace for consumers, let's say, for example. It is a particular population that has a great desire and a focus on these messages.

And we are also very diligently involved in making sure that the behind-the-scenes experience works when people are presented with the new information and the new cards and that there is a facile transition, if you will, from one system to the next.

Mr. Johnson. Well, do you think you are on track to get it done expeditiously, in a year, I guess?

Mr. Kouzoukas. Yes.

Mr. Johnson. That is a positive answer.

Listen, I thank you for doing what you are doing. And I hope you can get the word out to all the seniors about the new Medicare cards. And I thank you.

I yield back.

Chairman Roskam. Thank you.

Mr. Levin.

Mr. Levin. Again, welcome.

I am going to resist the temptation to talk again, as I did in my opening statement, about what this administration is doing to undercut Medicare and Medicaid. Also, to resist temptation to talk about the legislation that I and others introduced relating to dental, visual, and hearing.

I instead want to focus in on the whole issue of value-based that you talk about. Because as I look about, those of us who were very much involved in the ACA talked a lot about value-based, and we undertook efforts in the ACA to move away from fee for service to value-based. That was somewhat, if not the origin of, the placement of emphasis on ACOs, on medical homes, and on the Center for Innovation.

And so I must confess, after you talked about the importance of getting better value for our investment, you then go on to say to make sure that patients are in the driver's seat, making their own determinations about the value and quality of the care they receive.

I mean, that is the rhetoric that we always hear, and, to some extent, I mean, we agree with it. To have patients more involved, to put them in the driver's seat, essentially, is used often as rhetoric to move everybody outside of the driver's seat.

So I just want to talk to you about what you have been doing. Apparently, CMS took steps relating to one of the experiments of the Center relating to hips and knees. We talked a lot about the need to try to bundle, to put together procedures, and to put together the providers that related to those procedures.

So you have taken steps essentially to undermine that experiment, to cut the number of sites, to make it voluntary. So tell me how you defend undermining or taking those steps that were put into ACA or into the instrumentality that led to this effort to try to address that procedure in a way that was value-based? How do you defend making it voluntary, reducing the number of sites?

Mr. Kouzoukas. Thank you very much for the question.

Mr. Levin. I am not sure you want to thank me, but go ahead.

Mr. Kouzoukas. Well, I do, because I think we share the goal here of ensuring that patients have access to healthcare in a way that makes sense for them. And the way that we have thought about this, just to give you a bit of an analogy, is that when you go out to buy a computer, you are buying one brand or another; you are buying an entire computer. You are not buying 14 different parts of a computer and assembling it yourself. And I think that is important not only for the reasons that you mentioned, but also it is very consistent with the philosophy that I laid out of patient-driven healthcare.

Mr. Levin. Okay. I understand that. But how do you defend the steps that you have taken to erode that experiment? How do you defend it?

Mr. Kouzoukas. I think what we have seen, and the diversity and breadth of the committee's membership here today reflects it, is that healthcare in this country really varies quite a bit across the entire Nation, that a lot of regions have different arrangements, different cultures, different kinds of markets that have emerged.

And what we are trying to do is ensure that as we embark on this journey together and work with the committee and others to get to that common shared goal, that we do it in a way that reflects and builds upon the experiences of each community and that we provide as many variations and options to people as possible, so that as we get there, we do it in a way that makes sense for each community.

Chairman Roskam. Mr. Buchanan.

Mr. Buchanan. Thank you, Mr. Chairman.

I appreciate the opportunity for both of you to be here today.

Let me ask you: in our area, as you can imagine, we have a lot of seniors. I talk to a lot of different patients and some doctors. Everybody is a little bit concerned about cyber-attacks. And I guess there have been some threats in the past and some reality of these cyber-attacks.

As we move forward with the systems that we are talking about, where are we at? What is CMS doing about preventing that? And then I would add, are there any incentives for docs to make sure that we are doing as much as we can? I would like to hear from both of you on that issue.

Mr. Kouzoukas. Great. I will start, and then Kate will have something to add.

One of the most important things we are doing is the work that Mr. Johnson asked us about, which is that we are working hard to ensure that Medicare beneficiaries are identified by a different number than their Social Security number, what we call the HICN, or healthcare identification card number.

And this number, as you know, largely overlaps with the Social Security number, and that presents an opportunity, if there is a cyber breach of some kind, for bad people to take advantage of not only the government and individuals. And so we are working hard to ensure that new system is rolled out in a way that makes sense and protects the integrity of the system and for seniors.

We also, obviously, take a great deal of care with regards to the security and privacy of the information that we have. It is an incredible resource.

And it is really interesting. If you ever have an opportunity to visit our headquarters in Baltimore, when you drive up to the front gate, the security is really unlike any other Federal building, or most Federal buildings that I have the opportunity to visit, and it is quite intense.

I think sometimes when we have visitors come and meet with us there, they remark upon it. And I explain to them that while the work we do is really important, and we obviously take care to safeguard our headquarters, the reason that there is so much intense focus on the security is because we also have a lot of private information there.

And so it is really integral to what we do every day in all of our systems, all of our operations, all of our IT contracts, all of our vendors. We have woven cybersecurity and information security generally into our practice because we have had to. We sit on a treasure trove of information.

I will ask Kate to supplement that with anything she may have.

Mr. Buchanan. Dr. Goodrich.

Dr. Goodrich. Yes, thanks. A very important question. And something, as Demetrios says, we take very, very seriously within the agency.

So I can speak to what we are doing as it relates to what we ask of our provider community, and, in particular, for hospitals who participate in the EHR Incentive Program, also known as the meaningful use program, and for clinicians who are participating as part of the Quality Payment Program.

These providers are through these programs using certified EHR technology. And there are a number of things that we require of those providers as part of that program, one of which is that they conduct every year a security risk analysis of their EHRs. This is a critical component of the program. In fact, we are thinking about ways that we can further strengthen the emphasis on security and privacy as a part of that program.

Mr. Buchanan. Just as we move forward, my concern is with all of these registries and data information sharing. My sense is we have made a lot of progress in the last couple of years. Is that your thought as we move forward in this area?

Dr. Goodrich. Yes, sir. When we work with the registry community as part of these programs, we have certain parameters and requirements that they have to meet in order to be sort of CMS qualified, if you will, to participate in these programs, and some of those requirements are, indeed, around security and privacy of patient information.

Mr. Buchanan. With that, I yield back.

Chairman Roskam. Thank you.

Mr. Thompson.

Mr. Thompson. Thank you, Mr. Chairman.

Thank you both for being here.

Mr. Kouzoukas, I want to thank you in advance for something. My district experienced just a horrific fire this last year. We lost 7,000 homes. People were displaced. And, sadly, healthcare really took it on the chin. And my folks, my clinic folks, have been working with HHS to figure out how collaboratively to put the pieces back together, and you have been very helpful, I understand.

I just want to let you know that they think they are still going to be having trouble, and they are going to be calling on you for more help, and that would be greatly appreciated. So thank you very much.

Earlier this month, Administrator Verma announced that the MyHealthEData initiative would be focused on improving patients' access to their own health

records, and that was good to hear. However, we have been hearing that for about the last 10 years.

I want to know what we can expect will be different now than has been the practice over the last decade. Is there something that you can tell us that will convince us that, in fact, something is being done differently to force interoperability? And why is it that when it is not working, that doctors are the ones who are penalized rather than the providers?

Mr. Kouzoukas. Thank you. And it has been a real privilege to work with you and others to help communities that have been affected by disasters recover.

It really, I think, goes to show how important healthcare is to people's lives; it is such a fundamental piece of the social fabric, and when a natural disaster strikes, one of the first things that we are worried about, obviously, is how people who are sick or otherwise vulnerable are going to get access to the care they need and making sure that that infrastructure stays in place.

So, it has been a pleasure to work with you and the rest of the team at CMS on that.

As to your question about interoperability, I think that the particular focus we have got is unique, and it is unique because of its focus on the patient. And I will say that interoperability is obviously important. Any kind of efficient system is going to need to have pieces that work with each other and talk to each other.

But our focus in particular is not on interoperability for its own sake, but interoperability because of the opportunity that it presents for patients to be empowered, to have that access to their information.

And so in that regard this is distinct and this is different. And that focus will allow us to drive further, we believe, and deeper and more significantly to achieve an impact that is meaningful.

We also think that the work that we are doing to reduce burden and to ensure that the government's needs, in terms of collection of information and documentation and all the other kinds of hoops that we have the healthcare system jump through, that relieving that is going to allow us to focus providers' energies on the kinds of changes that they might need in order to achieve this vision.

So we are really excited about that work, and we will be looking forward to implementing it in the decisions that we have an opportunity to make in the coming time. And we also, obviously, welcome your input and that of the committee in how we can best achieve that vision because you have had the opportunity to see it evolve, as well.

Mr. Thompson. Thank you.

I would also like to know what you can tell us that we can expect will be coming about in regard to implementation of telehealth. That is one of the areas where we can do a heck of a lot of good in underserved areas, and we really need to roll that out to the best of our ability and to the maximum extent possible.

And lastly, I would just like to raise the issue of budget cuts to some of these programs that are so important. If you take over a billion and a half dollars from safety net hospitals, \$48 billion from the health workforce programs, and money from Medicaid, you really are undermining the whole system, and it can't be made up by providing opportunities for individuals to better shop for healthcare or even things such as rolling out a better telehealth program.

Mr. Kouzoukas. Thank you.

So with regards to telehealth, we couldn't agree more that this is an important initiative, not just for rural areas, especially for rural areas, because of the issues that are related to --

Mr. Thompson. Underserved areas, in general.

Mr. Kouzoukas. Indeed. And we also feel like it is an important part of healthcare in the 21st century, that we can't engage with the healthcare community in a way that doesn't recognize that technology in the world has changed.

There are some fundamental limits in terms of what Congress has imposed for how we deliver healthcare services in telehealth settings, but we are looking very hard at what we can do within our existing authorities.

I can also tell you that ultimately there is always this challenge of cost in the system with regards to your other question on resources. And ultimately, we think that if we put patients in the position to help drive that value, we are

going to get to that better place, partly with the vision that MACRA had in mind.

Chairman Roskam. Thank you.

Mr. Smith.

Mr. Smith. Thank you, Mr. Chairman.

And thank you, Mr. Kouzoukas and Dr. Goodrich, for being here today and sharing your insight and expertise.

I represent a rural Nebraska district where physicians face unique challenges in delivery of healthcare. I would say the most common grievance I hear from rural providers is the amount of administrative burdens imposed on them by the government, certainly due to limited resources that they have in carrying out their duties.

As you know, it takes time. It takes time away from caring for patients. And I appreciate the time and attention CMS is giving to reducing physician burdens in this way.

On November 2 of last year, CMS published its 2018 Quality Payment Program final rule for the implementation of MACRA. Can you outline some of the features of this rule that continue to provide flexibility for physicians to report that data, particularly those in small individual or rural practices?

Mr. Kouzoukas. Yes. And I have got to tell you that this notion of burden, it isn't just sort of an abstract idea that there is too much paperwork and process. It is very real. I see it every time I go to visit a healthcare professional or a doctor.

And I think that it is something that, in fact, I have experienced personally a bit of a change in how I interact with doctors when I go to see them in their offices, that I am spending less time with them, and they do seem to be buried into their devices, if you will. And I understand that that is part of the challenge here. So we are working really hard to address that in a lot of other ways.

And with regards to your particular question about the MACRA program and the regulations that we issued last year, I think we put our money where our

mouth is, if you will, sort of actions speaking loudly, that, in fact, we do recognize the challenges that small rural providers have.

We made two particularly important adjustments. One is that we raise the threshold, what is called the low volume threshold. That is the threshold that is the minimum sort of size or scope of a practice that you needed to have, if you will, before you are subject to the requirements and impositions and the opportunities, perhaps, that MACRA offers.

We increased that in order to recognize that we wanted to meet physicians and their practices where they are. We wanted to allow for that variation of community. And that in different communities, they are in different places along sort of the value spectrum.

We also made changes to allow for virtual groups. Virtual groups are an opportunity for physicians to join with others who aren't in their practice necessarily, but who they would like to be measured with as part of a larger group, if you will.

Those have been important accommodations. We are really excited about the changes they portend. And we are continuing to focus on this.

I will ask Kate to talk a little bit more about the reporting aspect.

Dr. Goodrich. Absolutely.

So as Demetrios says, this has been a critical issue for this program. We have heard many of the same things. I am a practicing physician. I know firsthand what some of those administrative burdens are, and they are particularly acute for clinicians in underserved areas and rural areas and small practices.

So, in addition to what Demetrios highlighted, we also provided a hardship exception for the Advancing Care Information, or health IT category, of MIPS for small practices who were unable to procure an EHR.

And then, finally, we want to thank Congress for providing resources under MACRA for technical assistance that is very specifically directed at clinicians in independent and small practices in underserved areas and rural areas.

We awarded these contracts now over a year ago, and since that time, they have been working directly with these providers to help them understand the

program, to help them be able to meet the requirements of the program, and ultimately to be successful.

Mr. Smith. Thank you. I yield back.

Chairman Roskam. Ms. Sewell.

Ms. Sewell. Thank you, Mr. Chairman.

And thank you both for being here today.

As we examine the implementation of MACRA, we must acknowledge that, first, our healthcare system is supported by payments from Medicare and Medicaid. So the President's proposal to cut Medicare by half a trillion dollars would send shock waves through the entire healthcare system.

And secondly, our reliance on emergent care is one of the largest drivers of long-term healthcare costs. There is a wide consensus that removing barriers to primary care is essential to restraining the growth of healthcare spending.

As we discussed our transition to a value-based payment system, one of the barriers I would like to discuss is transportation. But, first, I would just like a yes-or-no answer, Deputy Administrator. Can you give this committee assurances that rural hospitals and rural providers will not be adversely affected by this administration's cut in Medicare?

Mr. Kouzoukas. We have been working every day to ensure that the programs that we undertake and the way that we implement them recognize the unique needs of rural providers. And so I assure you it is very much at the forefront of our minds. And we have made adjustments and will continue to do that.

Ms. Sewell. Well, I just want you to know that, just like my colleague from Nebraska, I have a disproportionate amount of folks in my district that live in rural areas, remote rural areas, actually. And I can't tell you how many hospital closings I have gone to in the 8 years that I have been a Member of Congress. And it is really unacceptable.

My constituents shouldn't be left behind just because our Governor didn't expand Medicaid, and we didn't get more money. I think that we have to look for creative ways to make sure that everyone has access to quality, affordable healthcare.

And so with that in mind, I would like to talk a little bit about one of the biggest barriers, which is transportation. So often many of my constituents can't make primary care appointments because of the long distance, and they don't have anyone to help get them there.

And so, it is costing a lot of money for us, actually, their dependency on ambulant care, by taking ambulances for emergency care. And clearly that is a cost driver. And I know we would save lots and lots of money if we could figure out ways that we could help people make their appointment.

There is lots of innovation when it comes to transportation. I know that in many urban areas Uber is, like, getting reimbursed by hospitals in order for folks to make their appointments. Clearly, it is more constrained in rural areas.

But I would love your thoughts on what we can do for nonemergency transportation needs when we come to Medicare.

Mr. Kouzoukas. I couldn't share your concern more. And if you think about it just from a human perspective, the situation of someone who has access to this wonderful resource that the Medicare program has made available, in terms of the scope and number and variety of providers to access the care. They have an appointment perhaps that is a provider that is ready and willing to take them and help them through their healthcare situation. And sort of the tragedy, if you will, of someone not being able to get there, but for lack of that last mile.

Ms. Sewell. It is a huge cost. I think it is said that our health system loses \$150 billion each year from missed primary care appointments.

And I can tell you: I have lots of constituents that call me. Sometimes they call our office to see if there is any way that we can help come get them to take them to primary care appointments.

It is unacceptable in this great country that we call America that people who have access to healthcare, who actually can, because of their situation, Medicare and Medicaid; they actually have a card that will allow them to get healthcare, but they can't actually access it because of transportation barriers.

Do you see any way that we could have more innovative type of strategies to really deal with the very real barrier of transportation?

Mr. Kouzoukas. Absolutely. First of all, I would like to make us available to work with you on that. I think it is an area where there is an opportunity. And

the opportunity starts with understanding how we got here, which is a bit of this sort of Byzantine and fractured system that we have as a result of the sort of slow evolution and the rules that have sort of grown up around it.

There are some really bright spots, though, I think in the area of transportation. Medicare Advantage plans, for example, can offer transportation benefits.

Ms. Sewell. I worked on that.

Mr. Kouzoukas. Thank you.

We also had some recent guidance, or regulation, that was issued by the Inspector General's Office that sort of opened up some of the rules and limitations around transportation.

We also are, obviously, focused on really new and innovative models that might include transportation, but also might include care in the home.

Ms. Sewell. I would love to work with you on nonemergency transportation costs for Medicare.

Thanks.

Mr. Kouzoukas. Thank you for the opportunity.

Chairman Roskam. Ms. Jenkins.

Ms. Jenkins. Thank you, Mr. Chairman.

And thank you both for being with us today.

Mr. Kouzoukas, as we approach the first data submission period for MACRA, I join my colleagues in looking forward to reviewing the data and using it to help inform efforts to ensure the program is effective and meets the goals of enabling clinicians to deliver the highest quality and most efficient care.

I would like to applaud CMS for their leadership and for some of the important steps it has taken to ensure this program is carried out successfully.

MACRA has required tremendous investment, coordination, and education on the part of hospitals and clinicians. I personally continue to hear from hospitals

in Kansas that CMS' gradual approach to implementing the program and expanding MACRA's requirements has been critical to their ability to successfully integrate the program into their delivery systems.

I appreciate CMS' focus on regulatory relief in implementing MACRA. For example, CMS has allowed hospital-based physicians to use their hospital's value-based purchasing performance in the MIPS, beginning with 2019 reporting. For many clinicians and hospitals, this means more time improving care and less time reporting data.

Additionally, I commend CMS for factoring into the MIPS a complex patient bonus that accounts for the severity of illness and the number of dual-eligible patients and practices. This helps ensure reimbursement better aligns with the level of care a patient is provided.

One of the most important aspects of MACRA is the incentives for clinicians to participate in leading-edge alternative payment methods. These methods give providers a bonus for participating in models where they take on significant risk for managing the cost and quality of care for specific treatment episodes or across a population.

When looking at alternative payment models, I would like to emphasize, in light of the millions of dollars of investment which have been made by clinicians and hospitals to implement, it is critical that there be opportunity for those in one-sided risk models to benefit from the payment incentives in the advanced APM model track.

Could you share your perspectives on this?

Mr. Kouzoukas. Of course. And I think that it really takes us to the higher level and all-encompassing point that in approaching how we implement MACRA, we can't have a one-size-fits-all solution. And what we are doing in terms of how we implement it is that we are looking for opportunities to offer as many variables, options, and choices for physicians to participate in a way that makes sense for them.

We recognize, of course, that participating in APMs is going to involve some level of effort and, ultimately, risk. And MIPS offers, as well, sort of a building block, if you will, for how physicians can get there.

And it is interesting to think about the two programs in tandem, that we all share this. I think implicit within MACRA is a promise and a hope that APMs

are going to offer this ultimate destination of a patient-driven model, a value-based model, that is defined by patients.

How do we get there, given that each physician community, each healthcare community has sort of its own needs? We get there by, in part, for many physicians it is going to be through the MIPS program.

And if you look at what the MIPS program is comprised of and compare it to, say, a managed care contract, you see that it has a lot of the same elements. It has got some level of risk. And that is not just risk for its own sake. That is risk that is defined as risk, but it is ultimately about capital. It puts resources at the hands of the physician so that they can invest in that patient and support them through these kinds of ultimate transformative decisions.

It has got reporting, and, in particular, in order to enable that reporting, electronic medical records and the like. And it has got measures. And that is all about focusing on the patient.

So I hope that gets to the point of explaining how we support so many different kinds of communities in making this transformation, whether it be through MIPS or APMs, and all the different flavors of APMs that might come with it.

Ms. Jenkins. Okay.

Thank you, Mr. Chairman. I yield back.

Chairman Roskam. Ms. Chu.

Ms. Chu. Mr. Kouzoukas, I applaud the transition from fee for service to systems that would be more efficient, cost effective, and value-based. And that is why I am so glad to see the development of the Next Generation Accountable Care Organizations, or ACOs.

One of the ACOs is the all-inclusive population-based payment model. The model gives the ACO a set payment each month to cover the expected cost of providing care to Medicare beneficiaries.

I just happen to have the first ACO that signed up for this in my district. They were very excited to do it because they believed they could provide significant savings to the Medicare system while providing quality service.

However, they ran into an issue with secondary payer crossover claims or a billing error when a beneficiary had a second payer like Medicaid, and the providers were submitting the claims to CMS, but a missing step in the coding process had the unintended effect of double paying providers for treating beneficiaries with secondary insurance.

Well, thankfully, we were able to work this out with CMS, so I appreciate that. However, I am concerned that within the rollout of these new models, we will see more of these unintended errors as we try to reform the Medicare system.

So, Mr. Kouzoukas, could you discuss the steps CMS is taking to ensure that payment errors like the one that occurred in my district do not happen in the future?

Mr. Kouzoukas. Yes, of course. And I will say that, just in approaching the question, that part of the environment that we are operating in is one where we have got a very complex healthcare system with a lot of imperfections in its own right, as it existed pre-MACRA.

So I just want to make sure that we think about the new vision in comparison to the status quo, which has so many challenges in and of itself, and that has so many pieces of the puzzle that don't all fit together in quite the right ways. So there is risk even in not making change, I would say.

And I think that gets to my next point, which is, at some level -- not only at some level -- really fundamentally, the programs and the models and the demonstration projects that you are talking about and that we have been working on, they are experiments at some level. They are new startups.

And it is not something that the government has historically been very nimble and capable of pulling off in terms of iteration and constant change. But that is the task you have assigned us with MACRA and the opportunity you have given us to help improve people's lives.

And so I think that the answer to your question is that we will continue to be diligent, we will continue to get stakeholder feedback, we will continue to be open to concerns when we roll something out, we will, in advance of rolling it out, work as much as possible to get input about how things actually work. And we are going to work to engage in solutions that aren't manufactured here in Washington, but that we know have some precedent, some practice, perhaps, or an opportunity for improvement in the real world.

Ms. Chu. Thank you for that.

I am anxious to ask another question on a different subject, which is, I am a clinical psychologist by background, so I have a great interest in how mental health services are delivered in the Medicare system. Right now, the Medicare beneficiary population is growing three times faster than the number of psychologists providing services.

When surveyed, the psychologists have said that the number one reason they don't participate in the program is declining reimbursement rates. In the last 10 years, reimbursement rates for psychotherapy services have dropped an average of 17 percent, and rates for psychological and neuropsychological testing services dropped an average of 23 percent.

So, Mr. Kouzoukas, what is CMS doing to increase, rather than decrease, the number of mental health providers, like psychologists, in the Medicare system, at a time when the demand among beneficiaries is only increasing due to conditions like Alzheimer's and dementia?

And let me also say that the American Psychological Association is eager to meet with you to begin the dialogue on this, and I am hoping that that can take place.

Mr. Kouzoukas. First of all, we would like love to have a meeting. I look forward to the conversation.

I just want to ring in with my endorsement of the importance of the question, not only obviously for the care of so many people who suffer from mental diseases or have the need for mental healthcare services and behavioral health services, but also because of the opioids crisis. We believe that this is a key part of addressing the affliction that opioids has wrought on our communities.

I can say that we have done something very specific that gets right to the point that you are making, which is inside the physician fee schedule, the system, as you know, for how we pay physicians in Medicare.

We made changes last year to recognize that there is an important aspect of practices that don't have a lot of capital intensive needs, who basically operate with a desk and a chair and an office, essentially -- obviously, they don't have big expensive machinery or diagnostic equipment in their offices -- to adjust their reimbursement. And we set that out in the physician fee schedule last year.

I look forward to hearing about the improvement that it has hopefully made to address the very issues you raised. I look forward to discussing with you or others how we can do more.

Ms. Chu. Thank you.

Chairman Roskam. Mr. Marchant.

Mr. Marchant. Thank you, Mr. Chairman.

Mr. Kouzoukas, I have visited with some of the doctors in my district just recently and have heard from several of their physician organizations. Their biggest complaint is they say that the Stark Laws are creating real barriers to their coordination, and they are necessary to get them to succeed and participate in some of the new value-based programs.

Twenty-four different physician organizations representing 500,000 doctors have endorsed some legislation that I am an original cosponsor of, the Medicare Care Coordination Improvement Act, because they cannot participate in APMs under current law.

Can you speak for a moment about what CMS is doing to alleviate the Stark burden? And can I get a commitment from you to help serve these physicians and patients by working with me and the committee to help advance this legislation?

Mr. Kouzoukas. Yes, we will be delighted for any opportunity to work with you.

The particular legislation that you are referring to, I haven't had the opportunity to study. But I can tell you about a few exciting things that we are thinking about and working on in this area that I hope address your concerns in part, as well.

First of all, I think that the discussion of Stark as part of the entire dialogue and conversation we are having today is really important. It is an obscure law, perhaps, to those who don't have to deal with it, named after, obviously, Representative Stark. But it has a really big impact on how relationships are structured in the healthcare space.

And our focus on it is essentially a recognition that when we are talking about value-based care and ensuring that value-based healthcare has that

patient-driven focus, and that we are talking about creating a healthcare system that is not assembled in Washington, but assembled by each patient, you have to look at all the arrangements that are arrayed behind that physician that is facing the patient and the complex web of financial and other relationships that come about, partly as a result of the evolution of the healthcare system, to have so many fractured silos, to have so many rules and regulations that govern every part of the healthcare system.

We acknowledge that MACRA is just a piece of this, that we have got to look at the other parts, and Stark is an important piece of that.

I think that you will also see in the President's budget an important recognition of this with respect to the Stark Law. We do have a proposal in there that sounds similar to the concept you have described, and we look forward to continuing the dialogue.

Mr. Marchant. This bill is H.R. 4206. The author is Representative Bucshon. There are a lot of cosponsors, and I think all of us share in that. So I would like for you to review this, please, and present it to the chairman for possible consideration in a later meeting.

Chairman Roskam. Mr. Kind.

Mr. Kind. Thank you, Mr. Chairman. And thank you for holding this oversight hearing.

I would respectfully recommend that we have a lot more oversight hearings such as this, just so we can get some feedback on healthcare reform and learn what is working and what isn't working and find some bipartisan paths to move forward.

And I am glad my good friend Mr. Marchant just drew to your attention the bipartisan bill that we have introduced in this committee -- and they have a comparable one in E&C -- to address some of the problems we have with Stark and the anti-kickback provisions and the effect it has on our independent physicians in our districts and throughout the country.

So I am glad to hear that you recognize that there is a problem that needs to be fixed, and we look forward to working with you and the administration in order to find a path forward in order to address it.

Another problem that obviously existed within the healthcare system is the so-called sustainable growth rate, the SGR, the cliff that we faced every year, the box that we were in, with calling for huge draconian cuts to physician reimbursement payments. That created a lot of angst and a lot of concern about that taking effect, and every year, at the last minute, we came through with a pile of money to prevent it.

That, in part, was the reason why we needed this MACRA fix in order to move forward, but also to continue to drive the system to more value, to outcome, to performance-based incentives. And that, I think, holds some promise. If we can align the financial incentives the right way within the healthcare system, telling our providers, you know, you are going to be rewarded for doing good things, not just by doing more, but by getting good results, good value, good quality, at the end of the day, that is going to create a lot of innovation, a lot of change that we need to see throughout the healthcare system.

And, in that light, the previous administration had a goal of over 50 percent -- 50 percent of all Medicare payments being value- or outcome-based by the end of 2018. Is the current administration still on that track of hitting 50 percent by 2018? And if not, why not?

Mr. Kouzoukas. Our goal is to ensure that the healthcare system that we have, an opportunity and a privilege to create and influence for patients in the Medicare program, is the one that is right for each patient. And we think that APMs and value-based is an important part that, and, frankly, we think that there is really a big opportunity. It is hard to put a number on the size and the scope of the opportunity here in terms of where we think we can go and how bold we can be.

I think, ultimately, the check will be how ready people are for it and the timetable for it. And I think that the success isn't going to be measured by people's willingness and ability to come to where we put the windows and the doors for the --

Mr. Kind. Well, I appreciate, you know, hearing that from you. Obviously, you are not going to change the way you pay for one-fifth of the entire U.S. economy overnight, but I would just encourage you, don't let up too much on the gas as far as moving for value- and quality- and outcome-based payments. We need to keep that pressure on. Otherwise, the status quo is going to be the enemy of the reform that we need to drive this system.

And we know within Medicare where the major cost-drivers are. You know, it is not the per-capita spending per patient, which has been relatively flat the last 8 years since the Affordable Care Act was passed. The previous 10 years, we were looking at 7, 8 percent inflationary increases every year, and since then, it has been relatively flat. The real cost-driver now is the fact that we have 70 million boomers who are rapidly approaching retirement age, 10,000 a day joining the Medicare system, and the cost of prescription drugs. We ought to be having more hearings in Congress as far as bipartisan answers to the drug cost problem we have that is permeating the entire healthcare system.

Do you, the administration, have a list of proposals that you are willing to share with us today on how we can best address the cost factor with prescription drugs that patients rely on and need in the healthcare system?

Mr. Kouzoukas. Thank you. And let me address each part of the question.

First of all, with respect to letting up on the gas, I would like to assure you, don't worry about that, because I think that when we give patients a taste of the opportunity to be empowered for their own healthcare, when it is not that little kid I was, you know, helping my parents navigate the system, but it is instead someone who feels like they can make a choice and it matters if they go here or they go there, we are going to have --

Mr. Kind. I am glad to hear your commitment to that, but what about the prescription drug problem and the price?

Mr. Kouzoukas. So we can move quickly to get out of their way as they get there.

In terms of the prescription drug problem, and particularly in this context, I wanted to perhaps call your attention to the scope and breadth of the comment solicitation we made in the fall of last year in a document that we called the "New Directions: Request for Information."

And it set out the Administrator's and the Secretary's vision for bringing us into a new direction, a lot of the concepts we have talked about today. And drug pricing was a critical piece of that. We laid out a couple of things that gave people enough of a flavor for the kinds of things we want to accomplish on a bipartisan basis. And we have received over a thousand responses to the RFI generally. And we are confident and looking forward to working with you on solutions.

Mr. Kind. I hope to see more details in the future. Thank you.

Chairman Roskam. Mr. Paulsen.

Mr. Paulsen. Thank you, Mr. Chairman.

Mr. Kouzoukas, good to see you here, along with Dr. Goodrich.

You know, the annual doc fixes under the SGR formula and the way that doctors were paid for procedures and sickness is way behind us now, and we do need a full transformation toward value-based healthcare that drives that greater accountability and improved outcomes and quality and lower costs.

And MACRA and the alternative payment model is other Federal-based program accountability, which is the downside or the upside risk. It falls mostly on physicians and hospitals. But physicians, of course, don't treat patients in a vacuum. They order their tests, they prescribe medicine, they rely on electronic data, and they work with other physicians to achieve better patient outcomes and reduce costs.

Mr. Kouzoukas, or maybe Dr. Goodrich could also comment: What is CMS considering in terms of opening up opportunities for all stakeholders across the healthcare sector, various different stakeholders, to innovate, to collaborate in value-based arrangements both within and outside the context of MACRA alternative payment methods?

Mr. Kouzoukas. Thank you. I will start, and then Kate can jump in and add some here.

We are really excited about the dynamic that you are bringing to the table here about competition and bringing in new players. We really strongly believe that the system is going to work best if there is an array of choices.

And those choices might well come from the existing structures, but I think the Secretary has laid out in some of his speeches a willingness to be disruptive and a willingness to change the rules of the game in a way that are going to invite new forces into the healthcare system.

And I think you have also seen this in the "New Directions" RFI that I just mentioned and that the Administrator put out last year. The breadth and the scope of the creativity and innovation that is envisioned in that document I

think indicates a complete agreement with you that we need to be open to new players; we need to be open to innovative solutions.

And just to highlight some of the areas that are indicative of that: We specifically sought comment in that RFI on consumer-directed care, market-based innovation models, on physician specialty models, on prescription drug models as I just mentioned, on Medicare Advantage innovation models, on State-based and local innovation models with respect to Medicaid, on mental and behavioral health models, and on program integrity.

And I think that with each of those we didn't just list them. We talked about how and why this fit into this vision of a patient-driven, value-based healthcare system and the opportunities that exist to make changes that are going to be disruptive, that are going to bring about those new changes.

And it won't be just for its own sake. That sort of flexibility, that innovation, that disruption is also very much consistent with making sure that there is a solution for each community. Because every community, every patient, they are going to have their own needs, their own flavors. And the more we can do to ensure that the system that Medicare beneficiaries face and have an opportunity to take advantage of has as many different ways of interacting with them, of supporting them as they make those decisions, I think the more successful we are going to be and the more you are going to look back at the work you did in MACRA and be really proud about the new direction it brought us to.

Mr. Paulsen. And, Dr. Goodrich, maybe before you comment, just so I can ask one other question real quick and then you can both comment. We have a lot of Minnesotan medical device companies, others that want to be those stakeholders and be incentivized. One other important aspect of MACRA is the merit-based incentive payment system option for what are called eligible professionals to report more data and possibly receive a reimbursement bonus, similar to APMs.

What steps is CMS also taking to include specialty-specific measures, including those specific to physical therapists, for instance, or other rehabilitation providers, within MIPS for the 2019 reporting year?

Dr. Goodrich. So thank you for that question. I think that is a really important point you are making, that we have certainly heard from the clinical community that there aren't always the right measures or enough measures for particular types of specialists.

So one of the things that MACRA did was provide resources for us to work with specialty societies and other types of stakeholders to develop the right kind of measures, more outcome-based measures that are relevant for specialists. We recently in the last, I think, 2 weeks or so released a funding opportunity announcement for use of those funds under MACRA to work with specialists and with patients to develop measures in these areas.

And you mentioned physical therapists and rehabilitation specialists. Physical therapists and occupational therapists have long been enthusiastic participants of some of the legacy programs as well. The MACRA legislation allows us to include those types of clinicians in the MIPS program beginning in the third year of the program. So we are in the process now of developing our proposed regulation for the third year of the program, and so we will be making some proposals and suggestions around those types of clinicians, as well, in that regulation.

Mr. Paulsen. Thank you.

I yield back.

Chairman Roskam. Mr. Blumenauer.

Mr. Blumenauer. Thank you, Mr. Chair.

Welcome. I appreciate the thrust of your testimony.

I must say, you know, 3 years ago, MACRA was a step to end the charade that we are all tired of, putting off the theoretical cuts that we didn't want and fought aggressively to prevent. But the fix was based upon the notion that there were actually cost savings that we could better capture to be able to deal with the intent of the SGR, however flawed that it was.

Implementation would be a challenge, I think, under the best of circumstances, but I am more than a little troubled that we are looking at -- contrasting what you are talking about here in sort of encouraging tones -- that we are looking at a budget from the administration that is a third-of-a-trillion-dollar cut in Medicare over time. Medicaid is in the cross-hairs; efforts to undermine the work to pay value over volume, like the bundled payments for hips and cardiac care; and canceling some of the proposals to lower costs or making participation voluntary instead of mandatory.

So it appears that the administration on one hand is working against some of the very goals that you have here. And I know Mr. Levin has referenced that, and I think we all ought to be troubled by the schizophrenia on the part of the administration, by putting things in -- attempting to put things in motion that would undermine everything we are talking about here.

But I just would like to focus instead on an area that I think we ought to be able to work on, that I think you are fully capable of helping us implement. I have spent a lot of time working on end-of-life care. I am kind of the death-panel guy that we had here some years ago on committee, with an actually bipartisan effort to make sure that families' wishes and needs at that critical phase were taken care of. And we have made some progress, slower than I would like, but I think we have made some progress.

We have sent to the Secretary and the Administrator a letter that was from Senator Isakson, Senator Warner, Representative Phil Roe, who has been my partner here on the House side on these efforts.

We believe that CMS already has authority to develop patient-centered, advanced-illness management models to support individuals with serious, advanced illness. We also believe, as set forth in the letter, that better metrics are necessary to ensure we provide appropriate and high quality palliative and end-of-life care needs for these people with advanced illness that honors and aligns with their goals, values, and informed preferences.

The work we have been doing on a bipartisan basis is instead to actually help families know, respect those needs, and make sure that that expression of need is honored regardless of the circumstances. Because in the end of life, sometimes people are traveling; their circumstances are difficult to operate under.

We believe that CMS should consider strategies under the beneficiary engagement and incentive model to develop decision support tools that would empower patients and families to ensure that providers and caretakers are fully informed at every stage of their illness.

Now, I have been encouraged by some of the words we have heard from the Secretary and the Administrator. We really would appreciate your reviewing the correspondence and working with us to see if there aren't things that we can do that I am convinced would end up actually reducing financial burdens, but most importantly, giving people the care they want, deserve, and expect in some of the most difficult circumstances they will face.

So I commend the letter to you.

Mr. Chairman, I would ask unanimous consent to enter it into the record --

Chairman Roskam. Without objection, so ordered.

Pending Insert Submission

Mr. Blumenauer. -- and look forward to any reactions, advice, and counsel you have with the work we are doing both in this Congress for other legislative tools and making sure that you have the resources to implement this little slice, but something that could have an outsized impact on America's families.

Thank you for your consideration.

Chairman Roskam. So, Mr. Kouzoukas, the hang time on that question was really elegant, and it is sort of right at the end of Mr. Blumenauer's time. So let me just invite you to kind of quickly wind it up. And then, with your permission, I will inquire at the end of our time. But please respond.

Mr. Blumenauer. I am sorry, Mr. Chairman. I didn't mean to --

Chairman Roskam. No, no. Listen, you are a pro.

Please respond.

Mr. Kouzoukas. Thank you.

And it really brings home to me, I think, a really important point, which is patient-driven care is going to mean a lot of different things for where people are in their life and their care experience. And with Medicare beneficiaries, given the population, obviously we are talking about people who ultimately are facing that sort of difficult circumstances at the end of their lives inevitably.

And the support of how we can work as the Medicare program to support families in those situations, I couldn't think of a more noble and empathetic thing to do. You know, obviously, the greatest pain we have sometimes in our lives is going through those experiences. And the opportunity to work with you and others to help people through that is a real privilege.

Mr. Blumenauer. Thank you very much.

Thank you for your courtesy, Mr. Chairman.

Chairman Roskam. Mr. Reed.

Mr. Blumenauer. I apologize for the --

Chairman Roskam. Not at all.

Mr. Reed. Thank you, Mr. Chairman.

And I am going to echo what Mr. Blumenauer just said, just to follow up on his questioning. I support the efforts of making sure that we deal with end-of-life care, and that we have that conversation, especially as people go into Medicare. I see it as a great opportunity to have that discussion about what their wishes will be. And it also generates a lot of savings at the end of the day, given that we spend in the last 6 months of our lives our biggest healthcare dollars.

I also want to start by thanking you, Mr. Kouzoukas. We have talked before on issues dealing with diabetes. I am a father of a Type 1 diabetic, and I am co-chair of the Diabetes Caucus. Thank you for your work with Omnipod and other issues that got taken care of that you addressed and helped millions of Americans get a better outcome and a better care as we worked with that issue through your office.

That all being said, I just want to kind of back this off a little bit. You know, we got some material here, and we are getting prepared to go over the issue of going to this value-based reimbursement model, and I totally support and appreciate it. And I can just think of the people back home and the people I represent in western New York hearing the conversation we are having here today. And we are talking about a patient-driven system that we are trying to get to that will force competitive market pressure into the healthcare arena to get better outcomes and better value.

I have a list, to the chairman's point, you, and this is how sometimes we talk to our constituents: We have this new MACRA that is coming through HHS, and CMS is the one running it, and you have to talk to the ASPE, who will give you some advice as to what the volume-based is going to be based upon, and then you have to talk to CMMI. And I have 60-year-olds, 65-year-olds going, what the hell are you talking about, Tom?

And so, from my perspective to you, let's have a little exchange here. When you say you want to have patient-driven/outcome/value type of process brought into the Medicare system, tell me how to talk to that 65-year-old to say, and this is what we are doing, and this is how you can participate in the program now. With this new model that you are used to and all those acronyms, translate that to a 65-year-old who is going, "I have no idea what the heck you are talking about." Tell me how to give him or her information and say, this is how you can change healthcare system deliveries for you, your colleagues, and your peers.

Mr. Kouzoukas. Thank you. And it was a real privilege to work with you on the diabetes issue that you referred to, by the way. The work of the committee was, I think, quite substantial and helpful to us as we worked to find a way to a solution that recognized the needs of individual patients and recognized, as well, that we are moving -- we are now clearly into the 21st century, and innovation is a part of the healthcare transformation that we are all trying to achieve.

Mr. Reed. So tell me what to say to a 65-year-old when they interact with Medicare. This is what we are trying to get to them, and this is what you need to do to drive this better outcome and this better mechanism through Medicare.

Mr. Kouzoukas. I am going to tell you a little bit about how I try to explain what I am doing to my own mother, frankly --

Mr. Reed. There you go. Now you got it.

Mr. Kouzoukas. -- because it is a bit of a challenge. I think she thinks I move a lot of paper around sometimes, but --

Mr. Reed. How do you talk to her?

Mr. Kouzoukas. -- I want to tell her about how happy I am to have the opportunity to work on things that are going to make a difference in her life.

And what I talk about is what she taught me about being a shopper when I was growing up. You know, she was the one who made sure that we got the best prices, and if that meant going to three different stores for the grocery list and this store for one thing and another store for a different thing, that is how she pulled it off.

And I have talked to her about what I am trying to do is -- and along with all of the colleagues and Kate and so many other good civil servants who are working with us, is that we are trying to give her that opportunity too, that when it comes to the doctor that she goes to when she falls and hurts her knee on a Saturday afternoon, that she isn't just going to the first name out of the phonebook and she isn't --

Mr. Reed. What do you envision for her to be looking into? That is what we have to send to the American people. They don't get it. I am just telling you, with your mom, that is a great conversation, and I appreciate that, but they don't

get it. They are like, I don't see that happening. What are you trying to tell them we are getting to?

Mr. Kouzoukas. Sometimes I talk about other complex decisions that she might make in her life, like choosing an auto insurance policy or a car insurance or a house insurance. Obviously, this is far different. This is about your own personal health. So I don't mean to say that it is the same. But I say, well, when we sit down and figure out what the right car insurance, what the right auto insurance --

Mr. Reed. What information are you looking to tell your mom to give to her doctor? What are you telling your mom to be able to make sure to give other people the opportunity to get that transparency?

Mr. Kouzoukas. I want to make sure that she knows that she has confidence and comfort in the person she is going to be dealing with and that she is not forced to just go to sort of the random person who is there and that she feels like she has a choice. If she doesn't like the experience and she doesn't think she is getting good care, then she is working with someone who is going to give her the right things that fit for her.

Mr. Reed. And just in closing, I just want to be honest with you. That is not getting to the people back home. It is not being delivered. They have no idea what you are trying to do. And when you talk in the language you talk here, they don't get it. And all they say is, "It is a bureaucracy. It is driven by the bureaucracy. And there is nothing I can do about it." So we have to do a better job of getting through that.

Mr. Kouzoukas. I think our challenge has been that there is so much structural work that needs to be changed that by the time it sort of translates into an action that they see -- we are going to get there, but we are working on pieces that are so far behind the scenes right now -- sorry.

Chairman Roskam. Mrs. Black.

Mrs. Black. Thank you, Mr. Chairman. I guess I will wrap this up, or maybe you will do the final wrap-up.

Oh, Mr. Kelly is to my right.

I apologize, Mr. Kelly.

I am taking up my time.

So, first of all, thank you, Mr. Kouzoukas, for being here, and Dr. Goodrich. We appreciate you being here because this is quite a complicated situation, as my colleague has already represented. And as a nurse for over 40 years, implementing commonsense policies that help promote patient-centered care like V-BID are at the top of my list and, I hope, a priority here in Congress as well.

With over 50 percent of my district in middle Tennessee being rural -- and I know we have already spoken a little bit about that -- these small, rural, and independent physician practices and physician-led groups are well-positioned to lead the transition to value-based care and succeed in new payment models, and I know they want to do that.

And while those large, institutional players continue to dominate many of the CMS current value-based care models, physician-led alternative payment models have untapped potential to improve the outcomes and reduce the costs.

So, along with addressing the burden of the MIPS on those small and independent practices, what is CMS doing to make it more feasible for physician practices and physician-led groups of all sizes to take the downside risk and to move into the advanced alternative payment models?

Mr. Kouzoukas. Thank you for the question. And I am delighted to also hear within it a nod to the work we have done within MIPS to ensure that that program enables practitioners and physicians to be successful in making this transition.

As we look at APMs themselves as sort of another category here, I think the bottom-line answer is that we are working to create more APMs. And I think the "New Directions" RFI that the Administrator put out in the fall really highlighted the breadth and scope of how broadly we are thinking about that. And I think the more APMs we have, the more variations there will be for physicians to find the one that is right for them, and that that will have its own success.

The other thing I think that is really important is that, as we consider what those APMs look like, we can't adopt a one-size-fits-all-approach. We have to really acknowledge the need to meet people where they are and that there are these regional variations.

And then I wouldn't stop there. I will say that in 2019, the new all-payer combination APM is coming in, and the real opportunity there -- I know we are throwing around a lot of acronyms, obviously. But what that does, as you know, is it creates an opportunity for physicians to count their participation in private plan APMs, as well as Medicaid managed care and Medicaid Advantage APMs, towards the threshold amounts that qualify for APM status and the APM bonus. And so that is also going to, I think, provide an opportunity for the practices that you are talking about to really participate.

And we haven't stopped there. As you may have noticed, in last year's rulemaking, we also indicated that we are working on a demonstration project, and that work is still under way -- a really exciting demonstration project that would create an opportunity for physicians to count towards their APM participation measure the Medicare Advantage panel size that they have and the number of patients that they have or revenue derived from Medicare Advantage in a two-sided risk arrangement.

And all of those things -- I mention all of them, and I go on a little bit at length just to give you a flavor a bit of the breadth and scope we are looking at for how to make this fit right for each physician, for each physician practice. And we are not doing it necessarily just for them, because we know that behind every physician there stands an entire group of patients who are counting on that physician to be successful and to help them navigate this system that we are working towards.

Mrs. Black. Well, thank you for that.

And I want to also mention -- I know I don't have much time left—that I am really interested in knowing what will be done on innovative benefit designs, such as reducing or eliminating the cost-sharing for beneficiaries or creating a preferred relationship with their specialist. Because I know in rural areas that is very important to them, and that they would be able to participate in such programs as well.

Mr. Kouzoukas. I think that those are the kinds of things that we specifically sought some comment on in our "New Directions" RFI. And we have gotten over a thousand responses. We are continuing to work through them, and we are really excited about the opportunities that we have seen in those responses, as well as dialogue with others, regarding new models and new ways of thinking about the way that patients and physicians can interact and our role in the Medicare program.

Mrs. Black. Very good. Thank you.

I yield back, Mr. Chairman.

Chairman Roskam. Mr. Kelly, bring us home.

Mr. Kelly. I think we are home.

Chairman Roskam. No, we are not.

Mr. Kelly. Mr. Chairman, thank you.

Dr. Goodrich and Mr. Kouzoukas, thanks for being here today.

One of the things that I think all of us are trying to get to is how do we run a system that gets better by paying for value, right?

And last week, Mr. Kind and I launched a new bipartisan Healthcare Innovation Caucus. When we see that the United States has the highest cost of care per person in the world, we need to think critically about how we can control costs while improving quality for Americans. And I don't think it is too far of a stretch of the imagination that innovation is truly in the DNA of the USA, and I don't think healthcare should be any different.

One of the things I keep wondering about is that there seems to be such a disconnect between what we do in medicine and what we do in other business models that work in our society every day.

And I am an automobile dealer, so almost everything we do in our business is based on different guidelines that are out there. And for somebody who is a prospective car buyer, they can look at a number of different sites or pick up a number of different publications that tell them what they should be paying for a particular automobile based on how it is equipped.

We also have the same thing when it comes to doing repair work. There is something called labor time guides, Chilton time guides. They are based on time studies. And it will tell you exactly what these different operations should be taking and how much time it should be taking to do it.

Now, the key to being in that business, by the way, is that you can operate under the time guide. So if it says it is going to take 1.6 hours to do it, and you

can do it in 1.2 hours, you still get paid 1.6 hours, with the caveat that if the work isn't done right, you do the rework on it for nothing.

So I am wondering, just how close can we ever get in the public sector into actually taking a look at how things work in the private sector in how we can control costs by getting at what we do and spending more time actually on the job as opposed to inputting data continuously that takes away from our time in this case with patients, in this case with wellness programs?

And I will go back to something. I think when it comes to healthcare, this is a different conversation, but relating to the car business, do you remember an ad that was for FRAM, and it was a guy that held an oil filter? It was a mechanic, and he said, "You can either pay me now or pay me later," and he was tearing apart somebody's car. I think what we are looking at too often in healthcare is that we are paying later for things that weren't taken care of earlier. And I am talking now about wellness programs. I am talking about nutritional programs. I am talking about how we would get there.

So is there any other thing you can discuss on any type of an alternative payment program or method that would help out with this situation? I know you are working on it very hard.

This is one-fifth of our economy right now. I don't see it slowing down anywhere soon. It is going to get bigger. Medicare is chewing up quite a bit of what it is that we spend -- and Medicaid.

How do we get to the point where our providers can spend more time with patients and patients can spend more time with their providers, as we look at how we work on the data that is being submitted?

Mr. Kouzoukas. Thank you.

First, let me thank you for your leadership in establishing the Innovation Caucus. We are looking forward to learning more about your work and, I am sure, the productive energies of the Members who are working with you.

And I say that not just because you brought it up but because we fundamentally believe that innovation is a key part of this transformation. And, in fact, I think at times one of the wonderful things about our healthcare system is that we have brought so many innovative medical technologies forward. And, in many ways, I think it has been in spite of, rather than because of, the way that our system works at times, in terms of the reimbursement side.

And that is why we are very focused on innovation as a key part of this transformation. And if you start to sort of unpack that as just, instead of just innovation as a broad-minded goal, you think about what brings about innovation -- and this is sort of the process we have engaged in, in thinking about how we are going to get there. And innovation comes from people being willing to take risks and develop new ways to help people through their healthcare crises.

And how do they do that? Well, they are going to need resources. How are they going to figure out exactly whether or not something works? They are going to need to go out, and they are going to test it; they are going to need to get through all kinds of experience in the marketplace as well as the regulatory situation. And that means that they need to go to investors. And investors are going to provide them with capital. And what do investors want to know? They want to know what the ultimate reimbursement system is going to look like. They are asking those questions.

And so, the more we can do to create predictability around that so that investors can put their resources into things that help people fight cancer and other afflictions, rather than -- and I love social media and all the new technology, but I would rather have American investors putting money into helping people cure cancer than necessarily another sort of way to do social media. I can't even keep up with the ones the kids use now.

So we are very focused on that. And what we are doing in terms of that transition to action is that, if we lay out these patient-driven goals, if we design a system that ultimately empowers patients to make decisions about where they get their care, then the market will evolve to feed those patients' needs and to address them. And, ultimately, the investors will line up behind that as well.

And that will continue to create a very beneficial cycle, we believe, where we have the capital going into the right place to help the right kinds of new innovation that are going to help providers meet the needs of patients, and at the end, everyone benefits.

Mr. Kelly. Well, I want to thank you for what you are doing.

I know when the chairman first started up to become chairman of this Health Subcommittee, he said, "Wat we are going to attempt to do and what we are striving to do is to make sure we are delivering healthcare to people in an effective and efficient way that leads into their senior years, where they are healthier and they will be able to live a better life."

And I think we are all trying to get to that same point. So I appreciate what we are doing. I know it is very difficult, but I really appreciate what we are doing. We are going to continue to work with you every step of the way to make sure that our providers and our patients see the full effect of -- they get a return on that investment that America is making. So thanks so much.

Mr. Chairman, thank you. I yield back.

Chairman Roskam. Thank you.

So thank you for your testimony today, Mr. Kouzoukas and Dr. Goodrich. It has been insightful for us. And I think, in terms of our goals and notes in the areas that we wanted to cover, members either asked those questions themselves or you raised those issues on your own. And so that was really helpful.

Let me make one point and then ask sort of a blue-sky question. So, you know, I feel like the proctor. Okay, pencils down. And so here is this one quick point.

So I represent suburban Chicago that you grew up in, Mr. Kaczynski (sic). And we ended up having a discussion with one of the local hospitals who was recently surveyed by CMS in one of those formats with the Illinois Department of Public Health where somebody comes through with a clipboard and the whole thing. And they said, "Oh, you have a problem in this hospital." And they said, "Well, what is the problem?" "The problem is your HVAC system is 18 inches too close. You have a shaft that is too close to something." It was just ridiculous and obtuse. You know, this hospital is meeting every building code and fire code imaginable, and you end up in some level of consternation about this.

So I just bring this to your attention. You know, it is one of these ongoing issues. And this came up in sort of the regulatory relief discussion. And so I know that I am not alone, but that was just one solicitation in a roomful of hospital leaders, and they brought this to my attention. And I know that this is now to your attention at CMS and so forth.

But my larger point is, what should we be thinking? Because this subcommittee represents the entire spectrum of Congress. We represent it geographically, in terms of experience, philosophically, the whole thing. You have a wide range here. What do you want us to be thinking about, and particularly the next 5 and 10 years? What is the discussion going to be about

Medicare in the next 5 or 10 years? Stipulating that we understand the demography that Mr. Kind mentioned, the aging of baby boomers and so forth, but a little bit more blue sky, what are your last thoughts on what you want this subcommittee to be thinking about?

Mr. Kouzoukas?

Mr. Kouzoukas. Thank you.

Chairman Roskam. Did I put you in a Polish community a minute ago, by the way? I think I did. I think I called you "Kaczynski."

What should we be thinking about?

Mr. Kouzoukas. Thank you.

And thank you, as well, for raising the question about the hospital that you mentioned. It is really indicative, I think, of the kinds of things that we are trying to address.

And Kate, for example, has really been quite focused in many of her daily energies on a new initiative the Administrator has launched that we are calling Patients Over Paperwork. And the focus of it is to address precisely the kinds of situations -- I can't speak to that particular requirement, let's say, or situation, of course, but -- the kinds of requirements that are really distracting our healthcare providers from focusing their energies on solutions that this committee and the Congress and the administration are committed to in terms of helping deliver solutions for patients.

We are also working hard -- and Kate is a good part of this, as well -- on sort of a corollary effort to make sure that the measures that we use in MACRA and otherwise are meaningful ones, the Meaningful Measures initiative.

And so, very excited about the opportunity to raise it. I know that you offer that as sort of a critique on some level of the current system, but I also wanted to assure you that a big part of our work in this administration is to address those very kinds of situations and to address sort of the underlying concerns both with respect to the range of CMS requirements but also particularly with respect to MACRA.

And I think that leads me to sort of the blue-sky question and answer a bit. And I will say that there is sort of two parts, I think, to this. And,

ultimately, one part is the communication. I think Mr. Reed challenged me a bit to think about that in new ways. And this is where you all have been such good partners at times, because you do -- as much as I am talking about patients and communities, I am here in Washington now every day and working intensely with a team on driving this change. You all do hear from your communities so directly, and the kinds of input you give us about the way we talk about these things, the way we think about these things, that is a huge asset to us, to be able to engage in that dialogue with you.

I don't think there is a perfect answer. There has to be, obviously, a sort of way to talk about this in each place. But I think continuing to practice, frankly, how we talk about these things in good part to people so that they make sense, so that they aren't abstract sort of policy notions, but really present themselves as something that can make an impact in peoples' lives.

I think the second part comes back into just sort of more about what we are trying to achieve here, is really recognizing that, as hard as it is to put patients in the driver's seat, as difficult as that may be in some circumstances, that at the end of the day, it is really the only solution. Because the doctors, as much empathy and care and resources they might bring to a patient, at the end of the day, the patient is the one who is experiencing sickness, and the patient is the one making choices about their care, you know, whatever circumstance they are in.

And so that is so important. And I feel, in some ways, that I am telling you that value-based care means that the patients are in the driver's seat. And, to me, it is, in part, common sense because of that sort of fundamental fact.

And I think that if we don't lose sight of that point, that ultimately the patients are making these choices about how they access care and that we can support them by ensuring that they are in a position to access the care that they choose, that is right for them, to do so in consultation with their physicians, who will bring so much empathy and concern and expertise to their situations, and that we recognize the important role that families and communities play in supporting each individual patient, that if we do that, we will ensure that value-based healthcare isn't something that is created in Washington but an opportunity for each patient to decide for themselves and to assemble for themselves healthcare.

Chairman Roskam. That is very good.

Well, thank you both for your testimony today. It was insightful, and we benefited from it, and I appreciate it. We look forward to this continuing discussion.

Dr. Goodrich, that Patients Over Paperwork Initiative sounds very interesting, and I would welcome the opportunity for us to hear more about that, you know, in kind of a briefing setting.

Dr. Goodrich. We would be very glad to do that. We love to talk about Patients Over Paperwork.

Chairman Roskam. Okay. Yeah. Terrific. We are a welcome audience for that.

As a reminder, for the record, any member wishing to submit a question for the record will have 14 days to do so. And any members can submit questions after this hearing, and I would ask that the witnesses respond in a timely manner.

The committee stands adjourned.

[Whereupon, at 4:40 p.m., the subcommittee was adjourned.]

MEMBER QUESTIONS FOR THE RECORD

Questions for the Record
Hearing on Implementation of MACRA's Physician Payment
Policies March 21, 2018

Representative Kelly (R-PA)

Question: I sent a letter to Administrator Verma in November 2017 on a global pay model that would set up patient care networks, which are essentially very advanced accountable care organizations. What are your thoughts on this model that would allow those who are ready to take on greater risk with greater flexibility so that these networks can truly create efficiencies to produce better outcomes for patients?

Answer: We appreciate your letter and feedback on testing a Global Payment Accountable Care Organization (ACO) Model. We share the view that prospective, capitated payments for ACOs should continue to be explored. In addition, we agree that it is important to continue offering new opportunities for organizations to take higher levels of risk, in exchange for higher levels of reward.

We are grateful for the comments and thoughtful ideas, including yours, that we received in response to the Center for Medicare and Medicaid Innovation's New Direction Request for Information. We continue to review these submissions, and they will be an integral source of information as CMS moves forward with our agency-wide efforts to promote innovation.

Question: Advanced alternative payment models (APMs) under MACRA give physicians and hospitals a unique opportunity to take risks to improve outcomes and reduce costs. However, there are still several cost factors outside of their control, such as drugs, devices and tests. Secretary Azar recently spoke about both using experimental models in Medicare and Medicaid to drive value and quality throughout the entire system and removing government burdens that impede the value-based transformation, including in terms of allowing drug, device and therapy manufacturers to collaborate with payers and providers in value-based arrangements. What is CMS considering in terms of allowing stakeholders to innovate and collaborate in value-based arrangements? What limitations does CMS face in allowing value-based arrangements?

Answer: CMS is interested in incentivizing better health outcomes for beneficiaries at lower costs and aligning payments with value. Models that allow patients to drive their care can continue to improve outcomes while controlling drug costs. Models that contemplate novel arrangements between plans, manufacturers, and stakeholders across the supply chain, including, but not limited to innovative value based purchasing arrangements, and models that would increase drug pricing competition while protecting beneficiaries' access to drugs are of particular interest. We sought comments on testing new models for prescription drug payment in the Innovation Center's New Direction RFI, and we are reviewing the comments received and will take them into consideration as we develop new models.

Question: A recent survey found that only 23% of physicians feel well prepared to meet

the Quality Payment Program (QPP) requirements. As with any new system, there is usually a flood of questions from affected communities – and a well-planned customer service operation is critical to successful implementation. As the QPP goes into effect, what is CMS’s customer service plan for responding to a large surge in questions from physicians and providers?

Answer: We realize it can be hard for some practices to participate in the Quality Payment Program (QPP). To help clinicians be successful, we’re going to keep looking for ways to reduce burden, simplify the program, and provide flexibility. CMS offers a range of support to help clinicians and practices to participate successfully in the QPP and make the best decisions on how to participate. Many of these free and customized resources are available within the local community, including direct one-on-one support from the Quality Innovation Network – Quality Improvement Organizations (QIN-QIOs) and the Small, Underserved, and Rural Support initiative. Clinicians can also reach out directly to the QPP Customer Service Center through phone or email, or to learn about the available options for obtaining support. In addition, clinicians can learn about MIPS and get QPP support through enrolling in a Practice Transformation Network in the Transforming Clinical Practice Initiative.

Representative Higgins (D-NY)

Question: We are pleased to see that the Buffalo/Niagara region has been selected as a payer region for Comprehensive Primary Care +. This successful multi-payer model works to ensure that beneficiaries participating in Medicare fee-for-service, Medicaid, and commercial insurance have access to the highest quality primary care. There are many medically underserved areas in our region - what is the Centers for Medicare and Medicaid Services doing to ensure that CPC+ participation maximizes the ability of beneficiaries in underserved areas to participate?

Answer: The Center for Medicare and Medicaid Innovation’s Comprehensive Primary Care Plus Model (CPC+) is an advanced primary care medical home model that offers an alternative payment structure to provide additional financial support for practices to invest in care delivery. CPC+ brings together Medicare and other payers, including commercial insurance plans and state Medicaid agencies, in 18 regions to provide the necessary financial support for practices to make significant changes in their care delivery.

Across the U.S., CPC+ offers two tracks: Track 1 and Track 2. Track 1 practices are intended to be focuses on delivering comprehensive primary care and better meet the needs of patients. Track 2 practices have already developed these capabilities and are intended to enhance the breadth and depth of care they deliver, with a heightened focus on the assessment and management of patients with complex needs.

CMS has designed the model so that practices of all sizes, including small, independent primary care practices and practices serving rural regions across the U.S. can participate.

Representative Chu (D-CA)

Question: Mr. Kouzoukas, given the concerns with the quality of the S-10 worksheet data raised by Private Essential Access Community Hospitals (PEACH) and others, can you discuss what plans, if any, CMS has to audit the uncompensated care data that hospitals report on the S-10 worksheet? If CMS does not have any plans to address these concerns, can you discuss the rationale for using unaudited data?

Answer: We appreciate the importance of verifying the accuracy of the uncompensated care data that hospitals report on the S-10, and have taken steps to clarify the instructions for reporting this data, give hospitals an opportunity to revise their data to improve its accuracy, and to eliminate anomalies.

In November 2016, CMS issued Transmittal 10, which clarified and revised the instructions for the Worksheet S-10. Transmittal 10 is available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R10P240.pdf>.

On September 29, 2017, we issued Transmittal 11, which clarified the definitions and instructions for uncompensated care and added edits to ensure the integrity of the data reported on Worksheet S-10. Transmittal 11 is available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R11p240.pdf>.

We have also provided several opportunities for hospitals to submit corrected data on their FY 2014 and FY 2015 Worksheet S-10s to their MACs. Most recently, on December 1, 2017, we instructed MACs¹ to accept amended Worksheet S-10s of FY 2014 and FY 2015 cost reports submitted by hospitals no later than January 2, 2018.

Finally, to control for data anomalies, in the FY 2018 Inpatient Prospective Payment System Final Rule, we finalized a methodology to apply statistical trims to hospitals' cost-to-charge ratios (CCRs) reported on Worksheet S-10 to ensure reasonable CCRs are used to convert charges to costs for purposes of determining uncompensated care costs.

We will continue to work with stakeholders to address their concerns through provider education and further refinement of the instructions to the Worksheet S-10 as appropriate.

Representative Crowley (D-NY)

Question: In the Affordable Care Act (ACA), waivers to the Stark law were granted to health systems for the purposes of developing Accountable Care Organizations (ACOs). Under MACRA, we are encouraging physicians to make similar transitions to value-based care models. However, 23 specialty physician organizations and the AMA have said that the Stark law poses significant barriers to care coordination and have hindered

¹ Please see transmittal 1981, available at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1981OTN.pdf>.

their transition from MIPS to alternative payment models (APMs).

Do you agree that physicians who are working to develop and operate APMs would benefit from some modernizations to the Stark law, similar to what health systems are afforded as they develop and operate ACOs? If not, what is the difference between ACOs and MACRA's value- based care models that justifies this difference in treatment?

Answer: We agree that it is necessary to reexamine the impact of the physician self-referral law on healthcare and the obstacles it imposes on the development of alternative payment models. The President's Budget for FY19 included a legislative proposal to establish a new exception to the law for arrangements that arise due to participation in alternative payment models. The proposal would require the Department of Health and Human Services, in consultation with the HHS Office of Inspector General, to identify the types of arrangements and the minimum risk levels and level of participation in the model required for such exceptions. We would be happy to provide technical assistance on legislation to provide flexibility under the physician-self referral law to facilitate development of alternative payment models.

Subcommittee on Health (Majority)

Question: In the Quality Payment Program (QPP) year 2 final rule, CMS stated that they do not have the statutory flexibility to weight the cost performance category below 30 percent of the final score². Thus, Congress recognized the need for greater flexibility in the administration of MIPS. Last month, the Bipartisan Budget Act of 2018 (BBA) passed Congress and was signed by the President. Section 51003 of the BBA directs CMS to assign the Cost category a weight of "not less than 10 percent and not more than 30 percent."

The BBA further specified that for the next three years, "the performance score for the [Cost] performance category...shall not take into account the improvement of the professional involved." This indicates Congress' desire to continue a gradual transition into MIPS, especially in the Cost performance category. The BBA clarifies the flexibility that Congress intended to include MACRA.

How does CMS plan to use this new regulatory authority, afforded by the BBA, with respect to the Cost performance category? Does CMS anticipate the Cost performance level for CY2019 to be closer to the floor or the ceiling established in the BBA?

Answer: CMS appreciates the flexibility in the Bipartisan Budget Act of 2018 with respect to weighting the cost performance category in the third through fifth years of MIPS. In 2018, a

² The QPP final rule CMS stated: While we understand the concerns of commenters, section 1848(q)(5)(E) of the Act requires the cost performance category to be weighted at 30 percent of the final score beginning in the third MIPS payment year. We do not believe the statute affords us flexibility to adjust this prescribed weight, unless we determine there are not sufficient cost measures applicable and available to MIPS eligible clinicians under section 1848(q)(5)(F) of the Act.

weight of 10 percent was established for the cost performance category, and two measures will be used in this category: Medicare Spending per Beneficiary and Total Per Capita Cost. We will provide feedback to clinicians on these measures in the summer of 2018. In addition, in late 2017, CMS solicited feedback on 8 episode-based cost measures and a Field Test Report template for these measures. These 8 measures will be considered for use in the MIPS cost performance category in future years. For policies being developed for the third year of MIPS, CMS will closely examine the cost performance measures that are available, their applicability to different specialty areas, and additional measures that may be in development, and will determine the weight for this category, cognizant of the need to transition to a 30 percent weight in the sixth year of the MIPS program.

Question: In October 2017, CMS Administrator Seema Verma announced the “Patients Over Paperwork” initiative, which supports President Trump’s Executive Order that directs federal agencies to “cut the red tape” to reduce burdensome regulations. Through “Patients Over Paperwork,” CMS established an internal process to evaluate and streamline regulations with a goal to reduce unnecessary burden, to increase efficiencies, and to improve the Medicare beneficiary experience. According to a recent CMS meeting on this initiative, much of a physician’s work is actually comprised of non-patient related administrative duties, and making sure that practices do not run afoul of many regulations and rules.

How will CMS incorporate the agency’s “Patients Over Paperwork” initiative into the MIPS program? What about into bundled payments, like the new Bundled Payments for Care Improvement (BPCI) Advanced Model? Does CMS intend to pursue additional Stark reforms in order to reduce physician burdens?

Answer: In developing policies for the second year of the MIPS program, CMS focused on simplifying, reducing burden, and supporting policies that lead to better patient-driven care. Some of these policies include: increasing the low-volume threshold to reduce burden for those who find it challenging to participate in MIPS; allowing new exceptions for the advancing care information performance category, including for small practices; and setting the performance threshold in 2018 at a level that doesn’t require full data submission.

The Center for Medicare and Medicaid Innovation will approach new model design with a focus on reducing burdensome requirements and unnecessary regulations to allow physicians and other providers to focus on providing high-quality healthcare to their patients and with the aim to give beneficiaries and healthcare providers the tools and information they need to make decisions that work best for them. Specifically regarding the Bundled Payments for Care Improvement Advanced Model, CMS designed the model after considering evaluation results from previous CMS models, experience with bundled payment, and stakeholder input.

Finally, the President’s Budget for FY19 included a legislative proposal to reduce physician burden by reforming the physician self-referral law to better support and align with participation in alternative payment models.

Question: The BBA codified changes to modernize the application of the Stark rule. Does CMS need any additional authority to reduce Stark-related physician burdens?

Answer: While the BBA provisions modernizing the application of the physician self-referral (“Stark”) law codified regulatory writing and signature requirements for compensation arrangements that are exceptions to the physician self-referral law prohibition, added to the signature requirement flexibility to allow for signatures up to 90 days after the effective date of an arrangement, and codified the regulatory definition of holdover arrangements for leases of office space and for personal service arrangements, we agree that more could be done to modernize the law and reduce its burden on providers. For example, it is necessary to reexamine the impact of the physician self-referral law on healthcare and the obstacles it imposes on the development of alternative payment models. The President’s Budget for FY19 included a legislative proposal to establish a new exception to the law for arrangements that arise due to participation in alternative payment models. The proposal would require the Department of Health and Human Services, in consultation with the HHS Office of Inspector General, to identify the types of arrangements and the minimum risk levels and level of participation in the model required for such exceptions. We would be happy to provide technical assistance on legislation to provide flexibility under the physician-self referral law to facilitate development of alternative payment models.

Question: According to CMS’s 2016 data, nearly 300,000 clinicians (25 percent) are slated for a reimbursement cut due to failing to meet the newly established reporting requirements under MIPS, while only 1.8 percent of clinicians (20,481 total clinicians) will receive a reimbursement bonus. Based on this CMS data, it is clear that clinicians need more assistance to adjust to MIPS and will require a longer transition period that might have been originally contemplated or expected.

Given some initial concerns with administrative burden under MIPS in the first two years, as well as clinicians’ inability to meet MIPS requirements, what can CMS do to provide relief? Would a longer transition period be appropriate and if so, does CMS have the authority to do so?

Additionally, are there ways to ensure clinicians are incentivized to see patients – instead of filling out forms – while adequately accounting for the four MIPS performance categories?

Answer: The numbers referenced in this question appear to be the payment adjustments in 2018 under the Value Modifier program, which are based on 2016 data. Starting in 2019, MIPS payment adjustments, based on reporting in 2017, is based on an overall structure that is different from the Value Modifier program.

2018 is the last year of the Value Modifier program. With respect to the numbers in the question, the nearly 300,000 clinicians who received a downward payment adjustment in 2018 under the Value Modifier program did not meet the minimum reporting requirements. In 2018, the overwhelming majority of clinicians received neutral (neither positive nor negative) payment adjustments. This is because the Value Modifier was structured in a way to provide adjustments

based on performance through a methodology that identifies a small number of groups and clinicians that are outliers (i.e., those with performance at least one standard deviation away from the mean composite score and statistically significantly different from the mean). The approximately 1.8 percent of clinicians (20,481) referenced above are those that are receiving a positive adjustment in 2018 under the Value Modifier based on this methodology.

MIPS payment adjustments begin in 2019, based on reporting in 2017, and are based on a different overall structure. MIPS was designed in the first year to allow clinicians flexibility and to establish transitional policies. In the second year of MIPS, many of the flexibilities from the transition year are continuing. Additionally, the Bipartisan Budget Act of 2018 includes several policies that will allow a more gradual transition in the third through fifth years of the program, such as greater flexibility in establishing the performance threshold. Finally, we have a strong focus on the need to reduce paperwork, and policies finalized for the second year of MIPS are aimed at reducing administrative burden.

Question: Congress specifically requested CMS give special consideration to the circumstances of small, rural, and health professional shortage area (HPSA) practices. CMS has responded with a variety of protections through rulemaking. Specifically, there are some protections regarding scoring and with the implementation of virtual groups. Based on CMS reports, it appears uptake of virtual groups is fairly low. We have heard that there is a reluctance to form virtual groups because they are required to recertify annually and there is the potential for changing requirements and limitations based on annual rulemaking.

Does CMS intend to continue these small and rural practice protections? If so, for how long? Has CMS collected information on how many virtual groups have been created? Of the groups that were created, what is their make up? Are they individual clinicians or are they groups of clinicians or some sort of combination? Have there been any barriers for clinicians to form virtual groups?

Answer: CMS recognizes the challenges faced by small and rural practices and wants to ensure that these practices can participate successfully in the Quality Payment Program without undue burden. In the second year of the Merit-based Incentive Payment System (2018 performance period), we have continued to provide flexibilities for small practices to further reduce burden. These policies include: raising the low-volume threshold; providing bonus points for small practices; setting the performance threshold at a level that doesn't require full data submission or require the use of an electronic health record system; adding a new hardship exception for the advancing care information performance category for small practices; implementing virtual groups; and for improvement activities, maintaining the reduced requirement for reporting activities. We continue to evaluate future policies under the Quality Payment Program cognizant of the needs and challenges of small practices.

2018 is the first year of the option to report through virtual groups. The policies were finalized through rulemaking in the CY 2018 Quality Payment Program final rule. In this rule, which was issued on November 2, 2017, we stated that we recognized the timeframe for virtual group formation would be short and would impose certain limitations for the first year of virtual group

implementation. We also stated that eligible clinicians who were not able to form virtual groups for the 2018 performance period should have sufficient time to prepare for participation in the 2019 performance period (82 FR 53603, 53608). We believe that as clinicians have more time to familiarize themselves with the virtual group policies and the process for forming virtual groups and reporting as such, there will be increased interest in program participation through this option.

PUBLIC SUBMISSIONS FOR THE RECORD



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

**Statement of
American Academy of Family Physicians
Submitted for the Record**

**House Committee on Ways and Means
Subcommittee on Health**

***Hearing on Implementation of MACRA's Physician
Payment Policies***

March 21, 2018

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The American Academy of Family Physicians (AAFP), which represents over 129,000 family physicians and medical students across the country, respectfully submits this statement for the record to the House Ways and Means Subcommittee on Health, on the Implementation of the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA).

1. The AAFP is Committed to the Quality Payment Program's Long-Term Success

Family physicians participate overwhelmingly in Medicare¹ are accordingly committed to the success of the new Quality Payment Program (QPP), as well as the Medicare program as a whole. The AAFP recognizes and appreciates the significant efforts of Congress and the Centers for Medicare and Medicaid Services (CMS) over the years to repeal and replace the failed Sustainable Growth Rate (SGR) formula, and to establish a payment system that promotes opportunities to deliver value-based care. As the Subcommittee looks back on the first year of physician participation under the QPP, the AAFP takes this opportunity to highlight key opportunities and challenges that we believe this Subcommittee can address in order to ensure the QPP's long-term success.

2. The AAFP Urges the Subcommittee to Take All Steps Possible to Promote Primary Care Alternative Payment Models (APMs).

MACRA included bipartisan support for Medicare to transition away from the legacy fee-for-service payment model for physician services to alternative payment models (APMs) that are designed to both improve quality outcomes and lower the total cost of care. **The AAFP urges the Subcommittee in the strongest possible terms to push for the testing, evaluation, and expansion of these new models—in particular those that allow primary-care physicians to evolve from, or even fully exit, the fee-for-service payment system.**

While fee-for-service payment may be appropriate for some aspects of acute or episodic care, it remains a suboptimal way to pay primary-care practices for the active management of patient populations over time. Unfortunately, the health-care infrastructure is still primarily built around the fee-for-service framework relegating the physician-patient relationship to brief face-to-face interactions. Paying by the individual episode or procedure encourages physicians to simply treat acute sickness when it presents, whereas broadening the payment to the patient incentivizes the primary-care physician to what they long to do: perform longitudinal, comprehensive patient health through prevention and chronic disease management.

Four primary-care APMs are in varying stages of refinement, testing, and evaluation, and we urge the Subcommittee to encourage the Secretary and CMS to bolster them:

- **Advanced Primary-Care APM (APC-APM).** The AAFP has designed a new primary-care payment model that is currently under consideration within several groups under the Department of Health and Human Services. In December 2017, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended unanimously that the Centers for Medicare and Medicaid Innovation (CMMI) test the model. Under APC-APM, primary-care practices

would be paid a risk-adjusted monthly global sum for most aspects of primary-care delivery (both direct patient-facing services and care management), as well as a performance bonus for decreasing hospital and emergency visits. Like CPC+ (see below), the APC-APM is designed to be a multi-payer model. The AAFP believes that the APC-APM provides an ideal opportunity to demonstrate that global payments for primary care can dramatically improve care delivery, while reducing overall cost and practice burdens. Accordingly, we call for the Subcommittee to strongly encourage HHS and CMS to test and implement the model as aggressively as possible.

- **Comprehensive Primary Care+.** CMS has designated the CPC+ initiative as an advanced APM under the QPP, meaning that CMS will pay practices that participate and achieve certain revenue benchmarks in the model a 5-percent bonus in each year between 2019-2024. CPC+ is a multi-payer model under which CMS and other commercial payers (including Medicaid programs and Medicaid Managed Care Organizations) make enhanced payments to physician practices to support advanced primary-care delivery. CMS is currently supporting CPC+ in 18 states. The AAFP has worked closely with CMS in the design and testing of this model; in fact, several of AAFP's senior leaders are CPC+ participants. The AAFP urges the Subcommittee to accelerate the testing and expansion of this model nationwide.
- **Independence at Home Demonstration.** Independence at Home (IAH) is a statutory demonstration project that pays primary-care practices to deliver care to chronically ill beneficiaries in their homes. The model has shown great promise at both improving quality and lowering the cost of care. Through the leadership of Chairman Peter Roskam and other members of this Subcommittee, Congress in February extended this demonstration program for two additional years. As the enrollment in this demonstration remains limited, the AAFP urges Congress to make this demonstration permanent and scale it up nationwide.
- **Other Programs.** The **Medicare Shared Savings Program** (MSSP) has had mixed results since its implementation. However, there is growing evidence that the physician-led accountable care organizations (ACOs) in Track 1 and Track 1.5 are providing high quality care and doing so in a manner that reduces the overall health care spend for the attributed population—particularly those with a primary-care base.² The AAFP also continues to support the **direct primary care model** (DPC). DPC, like other advanced primary care models, liberates primary care from fee-for-service and reduces the administrative burdens associated with traditional payment models. Subcommittee members Erik Paulsen and Earl Blumenauer have introduced legislation ([H.R. 365, the Primary Care Enhancement Act](#)) that would remove a legal barrier in the Internal Revenue Code, currently blocking the roughly 23 million Americans with a health savings account (HSA) from using their HSA funds for this model. The AAFP supports this legislation

3. The AAFP Urges the Subcommittee to Take All Steps Possible to Simplify MIPS

In addition to urging Congress and CMS to maximize opportunities for family physicians to practice in APMs, the AAFP also wants those physicians who elect to remain in fee-for-service to continue to succeed. Accordingly, the AAFP has devoted substantial resources to educating and supporting physician members who wish to remain in the QPP's fee-for-service pathway, known as the Merit-Based Incentive Payment System (MIPS).

A. Reporting Burdens Must be Scaled Back for MIPS to Succeed

Awareness of the detrimental impact of regulatory burden on physician practices has reached a tipping point. On one hand, the AAFP is gratified that policymakers, health plans, and regulators more fully appreciate that the crush of reporting mandates is impeding patient care. On the other hand, awareness alone is not enough—the AAFP calls on the Subcommittee to take swift action to remove red tape from Medicare, and particularly the MIPS program.

The AAFP urges the Subcommittee to follow the recommendations of both the Trump Administration and the Medicare Payment Advisory Commission (MedPAC), insofar as they recommend that Congress remove reporting for physicians among the four MIPS performance categories (quality, cost, improvement activities, and advancing care information). The President's FY2019 Budget Request to Congress envisions a MIPS program that "would not require any reporting from clinicians, thereby leaving more time for clinicians to focus on patient care."³ Similarly, MedPAC's most recent annual report to Congress (published March 15, 2018) recommends that Congress re-design MIPS in a way that "eliminates manual clinician reporting."⁴ The AAFP appreciates the work being done in this area now (for example this Subcommittee's Red Tape Relief Initiative, and CMS's Patients over Paperwork Initiative), and asks that the Subcommittee find a way to remove or at least dramatically simplify reporting in MIPS. Congress should at a minimum extend continuous-quarter reporting (rather than full year reporting) for MIPS across those performance categories that require reporting: quality, improvement activities, and advancing care information.

B. MIPS Scoring Must Be Fair

The AAFP is concerned that MIPS scoring—which ultimately pits physicians to compete with one another—may not be reasonably calculated to compare physicians fairly across specialties and across groups. The AAFP applauds Congress for giving CMS three additional years of authority in the *Bipartisan Budget Act of 2018* to set the MIPS performance threshold in a flexible manner as it continues to gain experience scoring physicians. Congress and this Subcommittee have wisely recognized that transitioning to value-based physician payment takes time and patience. More flexibility will improve the program, however. The AAFP makes the following additional recommendations to the Subcommittee, in order to strengthen the system and inspire confidence in MIPS scoring:

- (1) As long as reporting is required under MIPS, CMS should ensure parity in reporting across physician specialties. CMS currently requires physicians in MIPS to report six quality measures. While many more than six of the 271 MIPS clinical quality measures are suitable for family medicine, many specialties do not have six suitable measures, and therefore are not held accountable for reporting measures. Family physicians' performance should not be judged against physicians in specialties that are not required to report on all six measures. In addition, CMS should require all physicians to report data on six measures, using cross-cutting measures if necessary.
- (2) The cost measures under development at CMS are still evolving and potentially unreliable for measuring the value of primary care—particularly at the solo and small-practice level. The two cost measures that CMS plans to use for 2018 reporting (Medicare spending per beneficiary and total per capita costs for all attributed beneficiaries) were developed for use at the tax identification number (TIN) level and are not suitable for small and solo practices. For the purposes of the cost category and until CMS can create a more even and meaningful playing field of cost measurement, the AAFP would urge that physicians be held harmless if they cannot reliably be measured against at least one episode-based cost measure.
- (3) Physicians should have maximum flexibility in participating in MIPS. Physicians in similar practices that might be part of a larger, multi-specialty group should be allowed to report as a smaller sub-group, specifically for quality reporting. The AAFP also remains supportive of an opt-in pathway for physicians who are not eligible for MIPS due to the low-volume threshold.

¹ According to 2017 AAFP membership survey data, over 90 percent of AAFP's active members participate in Medicare, and over 80 percent accept new Medicare patients.

² See, e.g., Department of Health and Human Services Office of Inspector General, *Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality* (August 2017) (finding that during the first three years of the MSSP program, "a small subset of ACOs showed substantial reductions in Medicare spending while providing high-quality care." Further, these ACOs "maintained high use of primary care services, which can lower utilization and costs for other care, and reduced the use of costly services such as emergency department visits.").

³ U.S. Department of Health and Human Services, Budget in Brief for FY2019, at 66 (February 12, 2018).

⁴ Medicare Payment Advisory Commission, Report to the Congress, at 166 (March 15, 2018).

**Alliance of Specialty Medicine
Statement for the Record
House Ways and Means Committee
Subcommittee on Health
“Implementation of MACRA’s Physician Payment Policies”**

Wednesday, March 21, 2018

Chairman Roskam, Ranking Member Levin, and members of the Subcommittee, thank you for the opportunity to provide feedback on implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The Alliance of Specialty Medicine (“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. With the looming threat of yearly cuts in Medicare reimbursement due to the flawed Sustainable Growth Rate (SGR) removed, thanks to the Congress, and Members of this Committee in particular, Alliance member organizations can further these efforts with incentives and technical assistance provided under MACRA.

Importantly, the Alliance appreciates the approach the 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. 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, 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. 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. For those 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, 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.

Specialists from our respective organizations have been participating in efforts to develop episode-based cost measures, serving on CMS technical expert panels convened by its contractors. Throughout the process, specialists have worked diligently to ensure episodes are attributed to physicians fairly and accurately, and that physicians are not penalized for the cost of care outside their control. The process has been painstaking and requires considerable analysis for each and every discrete procedure and condition. It will be several years before a significant number of measures can be developed and refined sufficiently for accountability purposes. The additional time provided by the technical corrections will help ensure the readiness of these measures.

In addition, we appreciate provisions that allows CMS to more gradually increase the MIPS performance threshold year-over-year before reaching the "mean or median" standard. 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.

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 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.

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.

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 qualified clinical data registries (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. However, 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, yet there are inherent disincentives in MIPS that discourage clinicians from engaging in more robust reporting. These include the program's complexity and the time and resources needed to invest in reporting— particularly for clinicians choosing to report through a registry. 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. One idea is to allow exempted physicians the choice to report quality measures. Even if these clinicians are not scored or held to a payment adjustment, CMS should recognize their contribution to data collection and count it toward the establishment of benchmarks that are desperately needed for specialty 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.

While we appreciate the Commission's recognition of the challenges physicians face with participation in the MIPS program, 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, namely 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.



Implementation of MACRA's Physician Payment Policies

Statement for the Hearing Record
submitted by

American Society for Gastrointestinal Endoscopy

March 21, 2018

When Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015, it represented a cumulative, bipartisan body work that involved the input of hundreds of stakeholders over the course of roughly three years. Through the implementation of the law rests the opportunity to identify areas for improvement. The American Society for Gastrointestinal Endoscopy (ASGE), representing more than 8,000 gastroenterologists throughout the country, commends the U.S. House Ways and Means Subcommittee on Health for holding a hearing on the implementation of MACRA's physician payment policies, specifically the Quality Payment Program (QPP).

The ASGE appreciates the action by Congress this year to provide the Centers for Medicare and Medicaid Services (CMS) with continued flexibility for MIPS implementation. ASGE thanks this Subcommittee for its leadership that led to the enactment of these technical changes. When physicians participate in quality improvement activities, patients benefit and the potential exists for cost savings to accrue to the health care system. However, to realize these positive outgrowths, physicians must be first given the opportunity to succeed within the new MIPS and Alternative Payment Model (APM) payment structures.

Give MIPS Time to Succeed

The ASGE asks Congress to reject recommendations issued by the Medicare Payment Advisory Commission (MedPAC) to eliminate MIPS and to establish a new Voluntary Value Program (VVP). It is too soon to arrive at the conclusion, as MedPAC has done, that MIPS will not succeed at improving quality and encouraging cost-effective use of health care resources. ASGE also firmly rejects MedPAC's position that all clinicians, regardless of specialty, should have their performance assessed on a set of broad population-based quality measures. Such a move would disenfranchise physician specialists and damage the quality improvement infrastructure that physicians and their

professional societies have worked to build around actionable quality metrics that can have a demonstrable effect on quality and patient outcomes.

Minimizing Regulatory Burden on Physicians

Administrative and regulatory burden is a major driver of consolidation in the health care marketplace. Consolidation, in turn, can lead to increased health care costs, as well as to poorer patient quality and access to care. As highlighted by MedPAC in its March 2018 report, an increasing number of physicians have joined larger groups, hospitals, and health systems. As an example, MedPAC highlighted in its report that the share of physicians working in practices with more than 50 physicians grew between 2009 and 2014 from 16 percent to 22 percent, and that recent studies show that commercial prices for physician services are higher in markets with larger physician practices and in markets with greater physician–hospital consolidation. Minimizing regulatory burden can help small and mid-sized practices remain agile and competitive which in turn, can achieve improved quality and access to care without scale effects driving up health care cost.

ASGE concurs with MedPAC’s assessment that the burden on clinician practices to participate in MIPS is significant. Immediate steps must be taken to minimize this burden. MedPAC has proposed a simplified value-based purchasing program. While MedPAC’s approach might reduce clinician burden, it would simultaneously eliminate the flexibility of clinicians to report on measures that are meaningful to their practice and scope of services.

ASGE instead proposes that CMS adopt recommendations put forth by the American Medical Association that were developed in collaboration with several medical societies, including the ASGE, to revise the MIPS scoring approach and requirements with the goal of reducing the administrative burden of MIPS and enhancing the existing program. The recommendations, developed to work within the confines of the MACRA statute, aim to remove the category silos and harmonize the four categories to produce a more cohesive and holistic program and sharpen the focus on outcomes as opposed to just reporting. Importantly, clinicians would maintain the ability to select quality measures that are best suited for their scope of practice. In theory, reducing the burden of MIPS will free resources for physicians and practices to make the investments required for eventually moving into APMs.

Creating a Pathway to APMs

According to MedPAC, roughly 12-16 percent of Part B billing clinicians will be Advanced APM qualifying participants in 2018. MedPAC’s goal with the VVP is to make it unattractive for clinicians to remain in traditional Medicare fee for service. Yet, it is going to be extremely difficult to move the roughly 85 percent of remaining clinicians to Advanced APMs in the foreseeable future for a variety of reasons, including the lack of accessibility to Advanced APMs for many clinicians.

Another limitation to eligible clinicians pursuing participation in an Advanced APM is the threshold limitations for reaching the status of Qualifying APM Participant. To become a Qualifying APM Participant, a clinician must meet a specific Medicare payment or patient count threshold, which may not be easily attainable depending on a practice's mix of services. For example, gastroenterologists may be interested in participating in CMS' new Bundled Payments for Care Improvement Advanced model, which is an Advanced APM, but because all the gastroenterology-related bundles are inpatient bundles, gastroenterologists are unlikely to meet either the required revenue or patient count thresholds. Only Advanced APM participants that meet the thresholds qualify for the APM bonus payment and a guaranteed exemption from MIPS.

To encourage development and participation in Advanced APMs, ASGE supports and encourages Congress to act on the proposal in the President's Fiscal Year 2019 Budget that would allow clinicians to receive a five percent bonus on physician fee schedule revenue received through the APMs in which they participate regardless of whether they meet or exceed the payment or patient thresholds. As explained in budget documents, this change would reward clinicians along a continuum for their participation in Advanced APMs without imposing arbitrary participation thresholds. Removing the thresholds would also simplify the QPP.

ASGE also suggests that clinicians who participate in Other Payer Advanced APMs should also be allowed to claim an exemption from MIPS until more Medicare Advanced APMs become available for physician specialists.

Lastly, Congress can facilitate the movement of clinicians to APMs by waiving the Stark and Anti-kickback laws for physician practices that are developing or operating an APM. ASGE supports the Medicare Care Coordination Improvement Act of 2017 (H.R. 4206) as introduced by Reps. Bucshon, Ruiz (D-CA), Marchant (R-TX) and Kind (D-WI), which would remove the "value or volume" prohibitions in the Stark law. These Stark law prohibitions pose barriers to the participation of physician group practices in APMs. Even the mere threat of violating Stark impedes innovative payment arrangements. By granting physician practices the same waivers that were provided to Accountable Care Organizations in the Affordable Care Act, there will be more flexibility to move money around in the APM to create incentive structures designed to improve quality and encourage appropriate resource use.

Conclusion

The ASGE appreciates the Subcommittee's engagement and oversight of MACRA throughout its implementation. The ASGE asks the Subcommittee to support physicians as they transition to new value-based payment models by fostering early opportunities for success and eliminating barriers that impede advancement toward new payment and delivery designs. Congress can support physicians during this transition by:

- encouraging CMS to adopt the recommendations put forth by the physician community to revise the MIPS scoring approach and requirements within the confines of current MACRA statute;
- removing reference of payment or patient count thresholds from the definition of a Qualifying APM Participant at Section 1833(z)(2) of MACRA; and
- removing Stark law barriers to APM development and physician participation by passage of the Medicare Care Coordination Improvement Act of 2017 (H.R. 4206).

**Statement
of the
American Hospital Association
before the
Subcommittee on Health
of the
Committee on Ways and Means
of the
U.S. House of Representatives**

March 21, 2018

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to submit comments on the implementation of alternative payment models (APMs) in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Now entering its second year, the MACRA's Quality Payment Program (QPP) continues to have a significant impact, not only on physicians and others clinicians, but also on the hospitals and health systems with whom they partner to deliver care. There remains strong interest from the field in participating in advanced APMs to support new models of care, and to qualify for the bonus payment and exemption from the QPP's Merit-based Incentive Payment System (MIPS). However, opportunities to access the advanced APM track remain significantly constrained. In the calendar year (CY) 2018 QPP final rule, the Centers for Medicare & Medicaid Services (CMS) estimates that as few as 10 percent of eligible clinicians will qualify for the advanced APM track in 2018.

The AHA urges Congress to continue working with CMS to provide greater opportunity to participate in advanced APMs. In addition, we urge Congress to consider changes to the fraud and abuse laws to allow hospitals and physicians to work together to achieve the important goals of the new payment models – improving quality, outcomes and efficiency in



the delivery of patient care. Finally, opportunities remain to improve fairness and reduce burden under the MIPS.

BROADENING OPPORTUNITIES FOR ADVANCED APM PARTICIPATION

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

Despite the progress made to date, the field as a whole is still learning how to effectively transform care delivery. There have been a limited number of Medicare APMs introduced so far, and existing models have not provided participation opportunities evenly across physician specialties. Therefore, many physicians likely are exploring APMs for the first time. **As a general principle, the AHA believes the APM provisions of the MACRA should be implemented in a broad manner that provides the greatest opportunity for physicians who so choose to become qualifying APM participants.** Particularly in the early years of MACRA implementation, CMS should take an expansive approach that encourages and rewards physicians who demonstrate movement toward APMs. The agency also should ensure that it designs APMs with a fair balance of risk and reward, standardized and targeted quality measures and risk adjustment methodologies, physician engagement strategies, and readily available data and feedback loops between CMS and participants.

The AHA continues to be concerned that CMS's regulations only allow participation in APMs with downside financial risk to "count" toward the advanced APM track. This approach excludes current Medicare APMs with the largest number of participants, including Track 1 of the Medicare Shared Savings Program (MSSP). We urge Congress to work with CMS to expand its definition of financial risk in the QPP's advanced APM track to include the investment risk borne by providers who participate in APMs.

CMS's narrow definition fails to recognize the significant up-front investment that must be made by providers who develop and implement APMs. Providers who participate in APMs invest significant time, energy and resources to develop the clinical and operational infrastructures necessary to better manage patient care. For example, an AHA analysis estimated start-up costs of \$11.6 million for a small ACO and \$26.1 million for a medium ACO.

We appreciate that CMS has offered the Track 1+ MSSP model in an attempt to create a glide path to assuming downside risk. Nevertheless, clinicians participating in shared savings-only models are working hard to transform care delivery; under CMS's policy, their significant investments and efforts will not be sufficiently recognized. Regardless of

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

In addition, restricting the advanced APM track to models with downside risk may inhibit the movement toward APMs, especially among early APM adopters. If clinicians cannot engage with existing model participants – which have a head start on building infrastructure and engaging in care redesign – they instead must start from scratch. While we acknowledge CMS’s interest in encouraging providers to move toward accepting increased risk, such an interest must be balanced with the reality that providers are starting at different points and will have different learning curves. CMS should define financial risk in a way that provides a path for physicians who are interested in participating in risk-bearing models – particularly those who are exploring such models for the first time – rather than serving as a barrier to entry.

LEGAL IMPEDIMENTS TO IMPLEMENTATION OF NEW PAYMENT MODELS

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

Outdated fraud and abuse laws, however, are standing in the way of achieving the goals of the new payment systems, specifically, the physician self-referral (Stark) law and anti-kickback statute. These statutes and their complex regulatory framework are designed to keep hospitals and physicians apart – the antithesis of the new value-based delivery system models. A 2016 AHA [report](#), *Legal (Fraud and Abuse) Barriers to Care Transformation and How to Address Them (Wayne’s World)*, examines the types of collaborative arrangements between hospital and physicians that are being impeded by these laws and recommends specific legislative changes.

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

exclusively on ownership arrangements. Compensation arrangements should be subject to oversight solely under the anti-kickback law.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

As the MIPS is the QPP track in which the vast majority of clinicians will participate, the AHA believes it is vitally important that CMS implement the MIPS in a way that measures providers accurately and fairly; minimizes unnecessary data collection and reporting burden; focuses on high-priority quality issues; and fosters collaboration across the silos of the health care delivery system. To achieve this desired state, we have recommended that CMS prioritize the following policy approaches:

- Adopt gradual, flexible increases in MIPS reporting requirements in the initial years of the program to allow the field sufficient time to plan and adapt;
- Streamline and focus the MIPS quality and cost measures to reflect the measures that matter the most to improving outcomes;
- Allow facility-based clinicians the option to use their facility's CMS quality reporting and pay-for-performance results in the MIPS;
- Employ risk adjustment rigorously – including sociodemographic adjustment, where appropriate – to ensure providers do not perform poorly in the MIPS simply because of differences in clinical severity and communities they serve; and
- Align the requirements for eligible clinicians in the advancing care information (ACI) performance category with the requirements for eligible hospitals and critical access hospitals (CAHs) in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

CMS has made progress in addressing several of the above priorities. For example, in the first two MIPS performance years (CYs 2017 and 2018), CMS has used an incremental approach to increasing MIPS data reporting requirements, and reduced the number of required quality measures from the previous Physician Quality Reporting System. **In addition, the AHA applauds CMS for responding to our long-standing request to develop a facility-based measurement option for the MIPS that will be available in 2019. While we believe it could be adopted sooner, the option ultimately will help clinicians and hospitals alike spend less time collecting data, and more time improving care.** Congress can help make the reporting option even more effective by encouraging CMS to consider future expansion of the option to a broader array of facility types, such as post-acute care providers.

Furthermore, Congress should encourage CMS to continue refining its approach to accounting for both clinical and sociodemographic factors in measuring performance outcomes. CMS took an important step toward recognizing the impact of sociodemographic and other risk factors on outcomes by adopting a “complex patient bonus” in the MIPS in 2018. Clinicians receive up to five bonus points on their MIPS Final Scores based on a Medicare

claims-derived proxy for patient complexity (Hierarchical Condition Categories, or HCCs), as well as the number of patients dually eligible for Medicare and Medicaid that a clinician or group treats. Dual-eligible status is a proxy for sociodemographic factors.

However, experience from the use of HCC scores in the value-based payment modifier (VM) raises significant questions about its adequacy in accounting for patient risk. CMS used HCC scores to provide modest increases to performance scores to groups treating significant numbers of high-risk patients. Unfortunately, the results of the 2016 VM program show that group practices caring for patients with more clinical risk factors were still significantly more likely to receive negative VM adjustments. Furthermore, while dual-eligibility is an established proxy for sociodemographic status, there are others – such as income and education – that may be more accurate adjusters for particular measures. We urge that the patient complexity bonus be viewed as an interim step while more sophisticated adjustment approaches are developed.

Lastly, the AHA believes that any future changes to MIPS policy should be informed by data, experience and input from this field. That is why we believe the Medicare Payment Advisory Commission (MedPAC) recommendation in its March 2018 *Report to Congress* to replace the MIPS with a new voluntary value program (VVP) is premature.

The proposed VVP would withhold at least 2 percent of clinician payment unless clinicians either joined an advanced APM or agreed to be measured as part of a group on measures of “population-based outcome measures” (e.g., mortality, readmissions, hospital admissions), patient experience and cost.

The AHA is concerned that the VVP has been proposed without the benefit of data and experience to show where the MIPS is working well and where it needs improvement. Clinicians and the hospitals with whom they partner are at the very beginning of putting the MACRA’s policy requirements into action. In fact, the first performance period for the MIPS and APMs ended on Dec. 31, 2017; clinicians will submit data by Mar. 31, 2018. In addition, clinicians and hospitals already have invested significant resources to comply with the MIPS. Changing course on the MIPS so soon after program implementation could lead to confusion in the field and require clinicians to spend time and resources deciphering the requirements of a new program rather than on improving care.

The AHA also questions the feasibility of several aspects of the VVP. At the core of the VVP’s design is the requirement to join a group practice. The AHA has always supported the notion of clinicians coming together voluntarily to participate in clinician quality efforts as a group practice, as it provides a way to share resources and improvement strategies. However, the group approach that MedPAC proposes would introduce several practical problems. Specialist physicians may find it difficult to form or join appropriate groups because the broad population-based measures envisioned in the VVP may not apply to their work. Furthermore, there is considerable national variation in market composition and the ability of clinicians to collaborate on improving performance. We fear that some groups could be “groups in name only,” rather than true collaborations to enhance the quality of care. This would seem to run counter to the intent of the VVP.

Finally, the AHA is concerned by the heavy reliance on claims-based measures in the VVP. Without question, using Medicare claims data rather than requiring clinicians to submit chart-abstracted data entails less data collection effort on the part of clinicians. However, claims data cannot and do not fully reflect the details of a patient's history, course of care and clinical risk factors. Such information is crucial to performing the risk adjustment that most outcome measures require to fairly compare provider performance. As a result, many claims-derived outcome measures do not accurately reflect provider performance. Basing clinician performance on unreliable data would be highly problematic.

CONCLUSION

Thank you for the opportunity to share our views on the implementation of advanced APMs in MACRA's QPP. The AHA looks forward to working with Congress, CMS and all other stakeholders to ensure MACRA enhances the ability of hospitals and physicians to deliver quality care to patients and communities, and advance health in America.



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Statement for the Record

By

Margaret E. O’Kane, President

Of the

National Committee for Quality Assurance

On

The Implementation of MACRA’s Physician Payment Policies

Before the

United State House of Representatives

Ways & Means Health Subcommittee

March 21,2018

Chairman Roskam, Ranking Member Levin and distinguished Subcommittee members, thank you for the opportunity to share our thoughts on implementation of the Medicare Access and CHIP Reauthorization Act (MACRA).

The National Committee for Quality Assurance (NCQA) is a nonprofit that for 28 years has improved health care through measurement, transparency and accountability. We strongly support the effort to revise health care payment and delivery systems to reward the value, rather than the volume, of care. MACRA represents a critical milestone in this effort by moving our largest payer – Medicare – toward more value-based payments for physicians and other clinicians.

NCQA believes MACRA implementation to date is yielding meaningful benefits and advancing both value-based and patient-centered care. This includes support for Patient-Centered Medical Homes (PCMH) and Patient-Centered Specialty Practices (PCSPs). Medicare could enhance primary and specialty care, while relieving clinician burden, by providing auto-credit under MACRA's Advancing Care Information category to PCMH and PCSP clinicians for use of health IT.

As with any effort of this historical magnitude, we will need to refine MACRA to advance quality measurement and the technology to reduce the burden of reporting credible quality metrics going forward.

There are legitimate concerns about the significant time and effort currently required for clinicians to report quality measures and other data for MACRA. NCQA shares these concerns and is aggressively working to reduce reporting burden by promoting alignment of measures across Federal, state and private programs, converting existing measures to digital package formats that allow quicker, more efficient and accurate implementation, and encouraging the use of data intermediaries that extract quality measure data from electronic health systems without requiring clinicians or their teams to do more than is necessary to care for their patients. This will reduce burden, improve accuracy of results, allow for more meaningful measurement – including of outcomes – and support more timely feedback to clinicians.

There also are serious concerns about clinicians in MACRA's Merit-Based Incentive Payment Program (MIPS) choosing on their own which measures to report that Medicare will then use to adjust their payments. This allows clinicians to "cherry-pick" measures on which they perform best, which suggests that quality is higher than it actually is. It also makes it difficult if not impossible to provide meaningful apples-to-apples comparisons of quality among clinicians. The best way to fix this is to require reporting on core sets of quality measures specific to each clinical specialty.

Finally, we believe Medicare could better support Congressional intent for MACRA by revising its policies on MIPS "virtual group" to include low-volume providers.

We discuss these issues in detail below.

Patient-Centered Practice Auto-credit

NCQA greatly appreciates MACRA's recognition of and much-needed financial support for PCMHs and PCSPs, which includes auto-credit in the MIPS Improvement Activity Category. NCQA has the largest PCMH program, with approximately 20% of all primary care clinicians in our PCMH program, and the only PCSP program.

We believe Medicare should further strengthen this support for PCMHs and PCSPs by providing auto-credit for their extensive use of health IT in the MIPS Advancing Care Information (ACI) Category. Medicare provides ACI credit to individual Improvement Activity measures that use health IT in ways that meet ACI criteria. Medicare should also provide ACI auto-credit to PCMHs and PCSPs because of the strong focus on Health IT in standards for these programs. ACI auto-credit would reduce unnecessary burden for clinicians who have already completed the rigorous PCMH or PCSP recognition process.

Reducing Reporting Burden

We urgently need to reduce the time and effort clinicians spend to report quality measures so they can instead focus on patient care.

NCQA is working to minimize reporting burden. Measures and their specifications should align across different public and private payer programs for clinicians, networks and health plans. The data used to support these measures should derive from the care provided by clinical teams and documented in their health IT systems. Data from these electronic systems, without further clinician input, can flow to data intermediaries, such as qualified clinical data registries, health information exchanges, data analytics companies and cloud-based electronic health records. Data intermediators calculate measure results based on these data from potentially multiple data source through the application of machine-readable digital measure packages accessed through a cloud-based library of measures. A program such as NCQA's ONC-approved eMeasure Certification program would certify implementation of the measures and accuracy of results. Once data intermediaries complete certification, they could send results to Medicare and other payers to satisfy reporting needs of clinicians, networks and plans.

This approach can have several advantages over the current reporting system.

- **Reduced Clinician Burden:** Clinicians only need to enter data into electronic health records and systems that they ordinarily do in routine delivery of care to patients.

- **More Accurate Results:** Automated systems assess all data pertinent to each measure more comprehensively than most clinicians do when submitting quality measure data on their own. This greatly reduces chances for underreporting performance and better ensures that clinicians get full credit for the true quality of care they provide.
- **More Meaningful Measures:** Data in electronic systems are much richer than data in claims that are the source for most measurement today. Very importantly, they include the outcomes data that consumers and other stakeholders most want when assessing quality.
- **More Rapid Feedback:** Also, very importantly, this automated approach allows for much more rapid and meaningful feedback to clinicians on their performance. Today, clinicians deliver care in one year, report on that care the next, and see their performance scores yet another year after that. Data aggregators should be able to provide feedback in nearly real-time so clinicians can much more quickly identify gaps and make needed improvements.

While still a work in progress, we believe this approach is feasible and could begin functioning within the next 2 or 3 years.

MIPS Measures

Under current regulations, clinicians in MIPS may choose which measures they report on from a vast array of measures of widely different quality. Some specialties have multiple measures to choose from, while others have very few and/or few high-quality measures. Clinicians also may choose to report on only 50% of eligible patients for any given measure. NCQA, MedPAC and others believe this lets clinicians “cherry-pick” measures and patients on which they appear to perform best. Results therefore suggest that quality is higher than it actually is and impede the ability to make meaningful comparisons.

To fix this, Medicare should require clinicians to report on core quality measure sets specific to each clinical specialty for all eligible patients. Developing and refining meaningful core sets requires achieving broad consensus on which measures are most important for each specialty, and filling critical measurement gaps that exist for many specialties. There already are initial core sets for some specialties, and CMS is working to fill measurement gaps through its Quality Measure Development Plan.

Mandatory reporting of core measure sets for all eligible patients would:

- Eliminate cherry picking of measures and patients,
- More accurately identify and target efforts to address performance problems, and

- Provide consumers and other stakeholders with meaningful ability to compare quality across clinicians.

Virtual Groups

NCQA strongly support Virtual Groups, which allow clinicians to voluntarily join together to have their performance assessed jointly measured as a group. This provision in the law should let practices with small numbers of patients join together to have enough patients for statistically valid measurement. However, current regulations prohibit low-volume practices from joining MIPS and thus virtual groups. This is excluding large numbers of smaller practices from the move to value-based payment and potential rewards for high quality that Congress intended.

We believe Medicare can fix this by amending its low-volume definition to say these practices are ineligible for MIPS “unless they join a virtual group.” Medicare could further promote best use of Virtual Groups by exploring development of a test to determine in advance if a Virtual Group will likely have sufficient numbers for valid measurement. This would help fulfill one of Virtual Groups’ primary purposes of ensuring sufficient numbers for valid measurement. Medicare could also maximize the potential of Virtual Groups by providing bonus points to clinicians who join them, as it has provided bonus points for other desired clinician behaviors under MIPS.

Thank you again for holding this hearing. Please contact our Director of Federal Affairs, Paul Cotton at cotton@ncqa.org or (202) 955-5162 If you have any questions.