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MEDICARE PHYSICIAN PAYMENT REFORM AFTER TWO YEARS: EXAMINING MACRA IMPLEMENTATION AND THE ROAD AHEAD

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SIXTEENTH CONGRESS

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MEDICARE PHYSICIAN PAYMENT REFORM AFTER TWO YEARS: EXAMINING MACRA IMPLEMENTATION AND THE ROAD AHEAD

WEDNESDAY, MAY 8, 2019

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

The hearing was convened, pursuant to notice, at 9:31 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Chuck Grassley (chairman of the committee) presiding.

Present: Senators Roberts, Thune, Scott, Cassidy, Daines, Young, Wyden, Cantwell, Carper, Cardin, Brown, Casey, Warner, Whitehouse, Hassan, and Cortez Masto.

Also present: Republican staff: Jeffrey Wrase, Deputy Staff Director and Chief Economist; Brett Baker, Senior Health Policy Advisor; and Karen Summar; Chief Health Policy Advisor. Democratic staff: Joshua Sheinkman, Staff Director; Elizabeth Jurinka, Chief Health Policy Advisor; Beth Vrabel, Deputy Chief Counsel and Senior Health Counsel; and Maura Fitzsimons, Professional Staff Member.

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The meeting will come to order. And for all the members, and particularly for our witnesses who had to work so hard to get ready for this hearing, it is going to be kind of discombobulated. That is not the right word—it is going to be mixed up, you know, because we have five votes at 10 o'clock. So we are starting a half-hour early, and we are going to try to keep the meeting going by different people chairing the hearing so we can keep going. So I hope everybody will—I know everybody will cooperate, but it is not the best thing for a very important subject we have before this hearing to have it interrupted in this way.

I want to thank our witnesses for being here today. We look forward to hearing how physician payment reform and the Medicare Access and CHIP Reauthorization Act are driving good patient outcomes. This law of 4 years ago goes by the acronym MACRA. MACRA also took the historic step of getting rid of the flawed sustainable growth rate formula which, when it was passed, we did not think anything about it was flawed. We thought it was an answer to a lot of problems for keeping things updated regularly.

So, let me take a moment to go through the history of SGR, as the saga ended with a hopeful message. Congress established it in

1997 as a mechanism to control Medicare spending on physician services. The formula worked at first, but it was not long before it called for large reductions in payments that, obviously, we could not tolerate because they threatened access to care.

This then set in motion a perpetual exercise where Congress scrambled, usually once a year, sometimes twice a year, to prevent physicians from being cut in reimbursement. So 17 times that went on over a period of a decade. And each time, we kicked the can down the road without solving the underlying problem. Finally, 2015 came. Congress came together and passed the MACRA law by an overwhelming margin in both chambers. MACRA showed that Congress can still work together in a bipartisan manner when it is necessary, and we ought to be working more when it is not necessary.

This reminder reinforces my beliefs that the bipartisan Finance Committee process to lower prescription drug costs can also be successful. That is our present responsibility. It bodes well for making changes in Medicare to improve access to care for patients in rural and underserved areas. And a little bit down the road, that is another goal we are working on. And in fact, it is being worked on now. This is something that Ranking Member Wyden and I are committed to.

These bipartisan efforts also provide a glimmer of hope that Republicans and Democrats can join together to prevent Medicare from going broke. And I would urge people on both sides of the aisle to think about putting that high on the agenda. This is time better spent than trying to expand Medicare for all only for it to, invariably, end up available to none.

MACRA payment reforms established incentives for physicians to provide the highest quality of care at the lowest possible cost. Physicians can pick from two different paths. They can opt to be graded on metrics in a number of different categories, or choose to get paid under a different model such as single payment for bundled services. This committee held a hearing in 2016 on the initial plan by the Centers for Medicare and Medicaid Services to implement these reforms. While the CMS implementation remains a work in progress, the 2 years of experience allows us to take stock of how well these reforms are working.

So that is why we brought together this group of witnesses that we have, physicians and other experts who are at the forefront of these efforts. Physicians' organizations that represent different specialties and practice characteristics are at the table. This diversity of physician practice mirrors the varying needs of Medicare patients. It also highlights the inherent challenge of getting top-notch care to everyone, including those in rural areas.

I am proud that physicians in Iowa provide high-quality care while spending less than many other areas. This is a value that MACRA payment reform aimed to achieve. I look forward to hearing from our witnesses their analysis of it.

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

The CHAIRMAN. Senator Wyden?

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

Senator WYDEN. Thank you very much, Mr. Chairman. Mr. Chairman, this is another topic where you and I are working closely together, as we are on prescription drugs. And with the chairman's leave, I am going to make a brief statement on behalf of both of us, because there is some particularly sad news this morning. The legendary *New York Times* health reporter Robert Pear passed away yesterday.

And he was the gold standard of health-care reporting. The chairman and I were just talking about it. He was fair to everybody, Republicans on this committee, the chairman, Chairman Hatch. I am sure everyone who has worked on health care worked with Robert Pear. He was described as the most important reporter in Washington, DC that nobody had ever heard of. Also, he did not let anybody get away with anything, whether you were a Democrat or Republican.

And—this is a hard statement to make. Robert Pear probably remembered the amendment to the amendment to the amendment of some health-care bill 3 decades ago. And it was that commitment to professionalism that was so appreciated by Democrats and Republicans.

And I noticed this morning—all over the country for decades, everybody waited for a Robert Pear story. He was essentially the barometer of what the facts were in health care. And *The New York Times* had a slug called, kind of, "Health by Pear," something like that. *The New York Times* this morning said they are going to retire the slug.

And I just think for all of us, and this committee, the chairman—and I think about Chairman Hatch who also adored Robert Pear—this is a really sad moment, because a really good guy who cared passionately about people, and passionately about improving health care, and was always trying to appeal to the better angels, passed away yesterday, way too young at 69.

So, Mr. Chairman, thank you. I have a brief statement on MACRA, but——

The CHAIRMAN. You spoke for me as well, because he interviewed me an awful lot. And I always felt I was treated fairly.

Senator WYDEN. Four years ago—Robert Pear covered this too—the committee led the effort to revolutionize the way doctors are paid under Medicare. And basically what we did back then—I think Senator Roberts remembers this too—is we threw in the dustbin of history the old way of reimbursing for health care. "We are going to say it is not about quantity. It is about quality." That was the basic principle in stone that we engraved.

As the chairman noted, the MACRA law has now been in place for 2 years. We have been watching its implementation. There are a few, kind of key issues that we care about. The chairman and I have a strong view with respect to small practices in rural and underserved areas. Senator Roberts cares about this deeply too. The rural docs are the backbone of communities in a lot of ways. You do not have a rural life without rural health care.

So it is absolutely essential that as we reward value in health care, we make sure—I have heard Senator Roberts talk about this

many times; Senator Grassley and I are talking about it now. We want to make sure docs in small and rural practices are not left behind, otherwise that is going to degrade the care rural patients get, and we will have an even bigger gap between the cities and suburbs and the little towns.

Second, when it comes to assessing quality, we want to make sure that the docs are not going through bureaucratic water torture. They should not be just checking boxes all day long. We want to reward doctors for care that really—we want to reward all those who practice improved quality, what is impactful for patients' health. But we do not want to make this some sort of exercise in form-filling and bureaucracy and red tape.

The last point I want to make—I appreciate the chairman giving me this extra time—is we want to wring more value out of taxpayer dollars in Medicare while coordinating the care that seniors need. And we have done that through Accountable Care Organizations, medical homes, bundled payments—we have used a variety of approaches to do it.

And last Congress, we passed a historic Medicare bill. If you walked on the streets of Kansas, Iowa, Rhode Island, Nevada, anywhere you are, I do not think people would know, but what we did on a bipartisan basis is we said, you know, the Medicare program of 2019 does not resemble the Medicare program when I was director of the Gray Panthers, when Robert Pear started.

That program was about acute illness. You broke an ankle, you went to the hospital—Part A. You had a bad case of the flu, you went to the doc—Part B. That is not Medicare anymore. Today it is cancer, diabetes, heart disease, strokes. It is chronic illness. That is the whole Medicare budget. So we recognized that with our CHRONIC Care bill. It is going to be historic.

So I just want to close by mentioning the next step. The next step ought to be to guide countless seniors who are getting lost in this blizzard of modern health care-red tape, the forms, the prescription requirements, the instructions, the pill bottles—it is almost too much for a lot of the seniors with these chronic conditions to go through. And, if they are in traditional Medicare where we still have well over half the seniors, it is twice as bad as if they had coordinated care through Medicare Advantage or Accountable Care Organizations.

So, as a former basketball player, I want to put the next step in basketball terms. Every senior with chronic illness ought to have what I am calling a chronic care point guard, somebody who manages their care and makes sure that the docs have all the information and that they can work together. In basketball terms it was called having somebody running the floor—you know, basically coordinating everything. And whether a senior is in traditional Medicare or MA, whatever it is, this can avoid a lot of mistakes.

Mr. Chairman, thank you. I know it was a juggle for you, Mr. Chairman, to try to figure out how to do it. And you tried to give everybody notice, and we appreciate it.

And I look forward to working with you on what I will just say, again, is a very, very sad day for all of us who watched a good man work a lot, sitting right over there at that table. I am missing him right now, right at that table for 3 decades. Thank you.

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

The CHAIRMAN. Thank you for speaking about Mr. Pear, and you did accurately say that you spoke for me. And I was glad you informed me of it, because I did not know about it.

I am going to introduce witnesses now. Dr. Barbara McAneny just told me a little while ago that she went to Grinnell and the University of Iowa. So thank you for being here. She is president of the American Medical Association and has served as a member of the board of trustees of that organization since 2010.

Dr. John Cullen is president of the American Academy of Family physicians. He is a practicing physician in Valdez, AK.

Dr. Frank Opelka is a physician executive, a surgeon, and a medical director of quality and health policy at the American College of Surgeons.

Dr. Scott Hines is Crystal Run Healthcare's chief quality officer, medical director, and physician leader for Crystal Run Healthcare's medical specialties division.

And Dr. Matthew Fiedler is a fellow with the USC–Brookings Schaeffer Initiative for Health Policy. His research is focused on health-care economics and policy.

We are grateful for your taking the time to come and help us analyze MACRA. I always tell people you probably have very, very long statements that you want to put in the record, and they will be put in the record, and you will not have to ask.

Proceed with your 5 minutes, Dr. McAneny.

STATEMENT OF BARBARA L. McANENY, M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION, CHICAGO, IL

Dr. MCANENY. Thank you very much, Mr. Chairman. I am Barbara McAneny. I am an oncologist from New Mexico and president of the American Medical Association. Thank you for inviting us to this hearing on MACRA. As background, my practice is the New Mexico Cancer Center, which used to serve in Albuquerque and four rural centers. Recently we have had to close three rural cancer clinics.

Since the enactment of MACRA, the AMA has worked closely with Congress and CMS to promote a smooth implementation of the Quality Payment Program. We have worked closely with CMS to make needed improvements in the MIPS program each year and appreciate the technical changes to MACRA that Congress included in the BBA18 to simplify and improve the program.

Our work is not done. To the contrary, the QPP still needs significant improvements. Implementation of a new Quality Payment Program is a significant undertaking. Congress, CMS, and the medical community must continue to work together to make the program better for patients and less burdensome for their physicians.

First, we must continue to ensure that small and rural practices can succeed. The AMA has strongly supported the accommodations that Congress and CMS have made for small practices, including the low-volume threshold, which excludes numerous practices that see very few Medicare patients. We have also supported hardship

exemptions from the Promoting Interoperability category and technical assistance grants to help small and rural practices.

However, recent scores from the first performance year show that small and rural practices scored lower than the average for MIPS-eligible clinicians. This is why we need to continue to support small and rural practices and make sure all patients can succeed in MIPS to preserve the infrastructure for health-care delivery in rural areas.

Second, one important goal of MACRA was to provide busy physicians with a path to transition into new innovative payment models. To facilitate this transition, Congress provided a 5-percent incentive for physicians to participate in APMs during the first 6 years of the program. These payments were intended to allow physicians to invest in changing the way we deliver care. The AMA heard from many physician groups that are excited to take advantage of this opportunity. Unfortunately, during the first 3 years of the program, too few APM options were available for physicians. And now only 3 years remain, which is not enough time for physicians to transition to an APM.

The AMA is encouraged by our recent discussions with CMS Administrator Seema Verma and CMMI Director Adam Boehler and their commitment to implement physician-focused payment models that give physicians the resources and the flexibility that they need to participate in APMs, such as the new Primary Care First model announced in April. Therefore, we urge Congress to extend the APM incentive for an additional 6 years.

Third, the AMA is recommending that Congress replace the scheduled physician payment freeze beginning in 2020 with positive annual updates for physicians. The recent Medicare trustee report found that scheduled physician payments are not expected to keep pace with physician practice costs. As a result, the trustees say access for Medicare patients will be a significant issue in the future. Positive payment updates are needed to provide physicians a margin to maintain their practice as well as transition to more efficient models of care delivery. Therefore, we urge Congress to reinstate positive payment updates for physicians beginning next year.

Finally, the AMA urges Congress to continue to make technical changes to MACRA to simplify the program and make it more clinically significant. The AMA continues to hear from physicians that the measures they are required to report are taking time away from patient care.

In conclusion, the AMA thanks the committee for your work on this issue. And we remain committed to working with CMS and Congress to implement many of these improvements and to ensure that the MACRA program is successful.

Thank you.

The CHAIRMAN. Thank you, Dr. McAneny.

[The prepared statement of Dr. McAneny appears in the appendix.]

The CHAIRMAN. Now, Dr. Cullen.

STATEMENT OF JOHN S. CULLEN, M.D., FAAFP, PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS, LEAWOOD, KS

Dr. CULLEN. Thank you, Chairman Grassley, Ranking Member Wyden, and members of the committee. I am honored to be here today representing the more than 140,000 members of the American Academy of Family Physicians. I am a practicing family physician in Valdez, AK, a community of about 4,000 people. With my four family medicine colleagues, we staff an independent clinic in a critical access hospital 300 miles from the nearest tertiary care hospital. Our census area is about the size of Ohio.

Four years ago, the Medicare Access and CHIP Reauthorization Act, or MACRA, was signed into law, and today's hearing is an appropriate opportunity to step back and evaluate how this law is performing. After 4 years, the AAFP still considers MACRA an appropriate framework for the physician payments in the Medicare program. And while I will outline several concerns with how the law is functioning, the philosophy and the framework of MACRA remain consistent with AAFP policy. We are especially supportive of those policies that allow physicians to pursue delivery and payment models that support the delivery of comprehensive, continuous, and coordinated primary care rather than fee-for-service. We are also pleased with the low-volume threshold that has protected many rural and independent practices from the negative consequences of MIPS. While we strongly support the low-volume threshold, we are pleased that CMS has created an optional voluntary pathway for small practices to compete within the MIPS arena.

MACRA, through the Advanced Alternative Payment Model pathway, created an opportunity for physicians to pursue non fee-for-service payment models that support advanced delivery models. And MACRA also created an opportunity for physicians to create and propose Alternative Payment Models through the Physician-Focused Payment Model Technical Advisory Committee or PTAC.

On April 22nd, CMS and CMMI announced CMS's Primary Cares Initiative, one of two new primary care models that will expand opportunity to thousands of family physicians who will be able to participate in an APM. And one of those new models, the Primary Care First program, is largely reflective of the AAFP's proposal submitted to and approved by PTAC in 2017.

The AAFP continues to have collaborative engagements with CMS and CMMI on this important work. And, as previously mentioned, the AAFP believes that there are areas where the law could be improved. And, in our written testimony, we outline five areas of concern, but I am only going to focus on two of those. One is creating a culture focused on patient care, and the second is eliminating the complexity of MIPS scoring.

It is well documented that the volume and intensity of administrative functions are having a negative impact on physicians. And the AAFP is concerned that the complexity and the cost of administrative functions are creating practice environments that are more focused on administrative tasks than on patient care. And we should ask physicians to really focus on their patients and not checking boxes. And that is how we are going to improve patient satisfaction, outcomes, and Medicare costs.

A study published in the *Annals of Internal Medicine* found that primary care physicians spend 2 hours completing administrative tasks for every hour of patient care. We are concerned that MIPS has created a burdensome and extremely complex program that has increased practice costs and is contributing to physician burnout. Understanding the requirements and scoring for each MIPS performance category and reporting required data to CMS is a complex task and detracts from physicians' ability to focus on patients. Many of my colleagues are frustrated and angry.

The AAFP supports CMS's Patients Over Paperwork initiative but believes that more must be done to improve patient care within the MIPS program by reducing administrative burdens. And we urge Congress to work with CMS to reduce the complexity and the administrative burden of MIPS. The AAFP has outlined a number of technical corrections and policy recommendations in our written statement. I would like to highlight three.

First, MACRA established an annual increase of .5 percent in physician payments from July 2015 through 2019. We would urge the committee to extend that annual .5-percent payment for 5 more years.

Second, the AAFP would recommend that the exceptional performance bonus payments be reimagined to reward practices that achieve significant year-over-year improvement, versus rewarding those practices at the upper levels of annual performance.

And lastly, AAFP recommends that the 5-percent bonus for qualifying physicians participating in an APM be extended for an additional 3 to 5 years.

Again, we thank you for holding today's hearing and for your continued commitment to ensuring Medicare physician payment policies are contributing to the delivery of timely, affordable, and high-quality care to beneficiaries.

[The prepared statement of Dr. Cullen appears in the appendix.]

The CHAIRMAN. Dr. Opelka?

STATEMENT OF FRANK OPELKA, M.D., FACS, MEDICAL DIRECTOR FOR QUALITY AND HEALTH POLICY, AMERICAN COLLEGE OF SURGEONS, CHICAGO, IL

Dr. OPELKA. Chairman Grassley, Ranking Member Wyden, and members of the committee, thank you for inviting the American College of Surgeons to testify at this important hearing. The College supports MACRA's focus on quality and value. However, we are concerned that a hurried CMS implementation has resulted in quality metrics that left surgical care as an afterthought. We would like to spend our time today discussing how we would put quality and value at the forefront of patient care.

MACRA was intended to move payments away from fee-for-service in hopes of finding new means for rewarding a care team for improving quality and reducing costs for surgery. This requires a strategy that defines the surgical care team and creates value for the surgical patient. Defining surgical value is simply not in the wheelhouse of the insurance industry. Thus, CMS continues to struggle, especially when they rely on their skills as a payer to retrofit a tired fee-for-service payment model with sporadic measures

which do not make sense for the surgical care teams and outcomes patients seek.

For many physicians, the Merit-based Incentive Payment System has not—and given its current trajectory—will not serve as a driver of improvement in quality or reduction of cost. The greatest percentage of surgeons participate in quality reporting through the CMS Web Interface group reporting option, and many are not even aware of the measures reported. Measures available in the Web Interface are focused on screening, preventive care, and diabetes. In other words, surgeons receive credit for how well their group practice immunizes a population instead of assuring a patient has safe surgical care.

MACRA states that whenever possible, group measurement should reflect the range of items and services furnished by an eligible clinician in the group. But that is currently not the case. Many believe that other provisions of MACRA, such as the emphasis on registries and the pathway for APM creation and measured development funding, would create outlets for more specialty-specific measure development. But that has not materialized.

ACS has a vision for what we believe meaningful measure of surgical quality care looks like. We believe the quality of surgical care begins by setting evidence-based standards for care and ensuring the right infrastructure and systems are in place through measurement and verification, incorporating data at the point of care to inform surgeons' and patients' decisions. We would propose a surgical quality measurement structure that has three components: verification of key standards of care, clinical outcome measures, and patient-reported outcomes.

In 2017, the ACS published optimal resources for surgical quality and safety, referred to as the Red Book. This framework is based on decades of research and implementation of verification programs which have proven successful in driving better patient outcomes and surgical care. Standards drawn from the Red Book are now being used for the verification accreditation of hospitals on the basis of surgical quality and patient safety. Clinical outcomes and surgery can be measured based on a combination of claims-based measures combined with rigorous clinical data from programs such as the National Surgery Quality Improvement Program.

Finally, the addition of patient-reported outcome measures tailored in an episode of care bring in the patient's voice and can assess whether the care achieves the patient's goals, including functional status and quality of life.

While the focus of this testimony is improving incentives for quality and value, the American College of Surgeons urges Congress to put MACRA implementation in the context of the current Medicare reimbursement rates, which have not kept pace with inflation and do not adequately cover the costs associated with providing care. Furthermore, the ACS has great concerns about the structure of payments under MACRA in the years ahead. The modest statutory updates included in the law are now finished, and we will soon enter a 6-year period with no updates. This will likely result in real reductions to payments due to inflation and budget neutrality. Physicians will view the further implementation of MACRA from this perspective. The ACS would welcome the oppor-

tunity to further describe the physician payment landscape from our perspective and how this might affect the future of access to care.

In closing, what matters most to patients and providers is safe, more efficient, high-quality surgical care. ACS believes the intent of MACRA is correct. We, as the ACS, remain committed to you and look forward to working with Congress and the administration to ensure that we can get this right for our patients. Congress should encourage CMS to partner with the physician community to evaluate and test innovative evidence-based proposals such as the one we have described. We believe CMS has the authority to accomplish this but may benefit from additional guidance from Congress.

CMS would also require additional resources to administer the QPP in a way which refocuses the incentives toward higher-value care and improves the quality of care for Medicare patients. This would go a long way toward assuring the long-term viability and success of the QPP and MACRA programs.

The CHAIRMAN. Thank you, Dr. Opelka.

[The prepared statement of Dr. Opelka appears in the appendix.]

The CHAIRMAN. Now, Dr. Hines.

STATEMENT OF SCOTT HINES, M.D., DIRECTOR, AMERICAN MEDICAL GROUP ASSOCIATION, ALEXANDRIA, VA

Dr. HINES. Chairman Grassley, Ranking Member Wyden, and distinguished members of the Senate Finance Committee, thank you for the opportunity to testify before you today. I am Dr. Scott Hines, and I am here on behalf of AMGA, where I serve as chair of their public policy committee and member of their board of directors. AMGA represents multi-specialty medical groups and integrated delivery systems across the United States. More than 175,000 physicians practice in AMGA member organizations, delivering care to one in three Americans.

I am board-certified in internal medicine and endocrinology, and I am Crystal Run Healthcare's chief quality officer. Crystal Run employs over 450 providers across 50 different specialties in 20 locations throughout the lower Hudson Valley of New York State. We are among the first 27 Accountable Care Organizations to participate in the Medicare Shared Savings Program since 2012. In my role as chief quality officer, I have helped to develop and implement the clinical programs necessary to deliver value-based care to our patients.

Policy-makers in Congress and the administration have made clear their intent to transform the way health care is financed and delivered in this country. The need to move Medicare to value is evident today more than ever, and I believe Congress passed MACRA to drive that transition to value in Medicare Part B.

Our current fee-for-service payment system is not sustainable and is not the model best suited to provide coordinated, high-quality, cost-effective care to our patients. AMGA members are looking to Congress for a stable, predictable value program that creates meaningful and realistic incentives that motivate them to make the multimillion-dollar investment to chart a course towards value.

MIPS was designed as a transition tool, an on ramp to value-based payment in the Medicare program. However, CMS has not implemented MIPS as Congress intended. Under MACRA, MIPS providers would have the opportunity for positive or negative payment adjustments based on their performance, starting at plus or minus 4 percent in 2019 and increasing to plus or minus 9 percent in 2023. By putting provider reimbursement at risk, Congress intended to move Medicare to a value-based payment model where high performance was rewarded and poor performers were incentivized to improve through lower payment rates. Despite the MACRA statute, CMS has excluded nearly half of eligible clinicians from MIPS requirements through their MACRA regulations.

Because MIPS is budget-neutral, these exclusions result in insignificant payment adjustments to high-performing providers. Rather than a 5-percent and 7-percent maximum payment adjustment for high performers in 2020 and 2021 respectively, these exclusions are resulting in only a 1.5- to 2-percent increase. By excluding half of providers from MIPS, the system has devolved into an expensive regulatory compliance exercise with little impact on quality or cost.

Now, I understand the concerns for my colleagues, for physicians practicing in solo or smaller practices, and that the reporting burden on them is at times significant. However, we must recall that the MIPS program is a continuation of quality programs that have existed for years, where previously no one was excluded from participating, let alone half of those eligible.

For Advanced APMs, the other pathway to value under MACRA, the system's requirements need to be revised to allow for increased APM participation. To qualify for the program, providers must meet or exceed minimum revenue thresholds from APMs or a minimum number of Medicare beneficiaries in these models. These thresholds progressively increase over time, and AMGA members feel that these requirements are unrealistic, unlikely to be met, and will not attract the number of physicians and medical groups necessary to ensure the program's success. In fact, these arbitrary thresholds serve as a disincentive for AMGA members to make the multimillion-dollar investments needed to move to value.

By eliminating these arbitrary thresholds and extending the APM program beyond a 2024 sunset date, Congress would be indicating to the health-care community that it is willing to offer a stable and predictable risk platform to providers ready to move to value. I truly believe Congress passed MACRA to drive the transition to value in Medicare Part B. However, we have clearly taken a step back from this transition over the past 3 years by excluding half of eligible clinicians from MIPS and enforcing arbitrary threshold requirements for Advanced APMs.

On behalf of AMGA and Crystal Run Healthcare, we are ready to work with Congress and CMS to ensure that MACRA can serve its intended purpose in moving our Medicare system towards value. Thank you.

The CHAIRMAN. Thank you, Dr. Hines.

[The prepared statement of Dr. Hines appears in the appendix.]

The CHAIRMAN. Now, Dr. Fiedler.

STATEMENT OF MATTHEW FIEDLER, Ph.D., FELLOW, USC–BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY, BROOKINGS INSTITUTION, WASHINGTON, DC

Dr. FIEDLER. Chairman Grassley, Ranking Member Wyden, members of the Finance Committee, thank you for inviting me to testify today. My name is Matthew Fiedler, and I am a fellow at the USC–Brookings Schaeffer Initiative for Health Policy, but this testimony reflects my personal views.

I am honored to be here to discuss MACRA's physician payment provisions. MACRA made important reforms to the structure of Medicare physician payment with the goal of improving the quality and efficiency of the care received by Medicare beneficiaries. With 2 years' experience behind us, now is an opportune time to take stock.

I will start with what is working well. In my view, MACRA's bonuses for participation in Advanced Alternative Payment Models, such as Accountable Care Organization models with two-sided risk, have great potential. Recent research on ACOs, which account for most APM and Advanced APM participation in Medicare, has found that these models can reduce health-care spending while maintaining or improving quality.

There has been a substantial increase in Advanced APM participation as MACRA's bonus payments have been implemented. In 2018, around 9 percent of traditional Medicare beneficiaries were served by providers and ACOs with two-sided risks, up from 3 percent in 2016. MACRA's bonuses likely contributed to this increase, although other factors likely contributed as well.

The Advanced APM bonus has also encouraged CMS to be more aggressive in deploying APMs that create stronger incentives to reduce spending. This includes making needed improvements to the calculation of the benchmarks used to judge ACO spending performance and increasing how quickly ACOs must transition to two-sided risk. While I am optimistic about MACRA's Advanced APM bonus, I am pessimistic about MIPS. MIPS's approach of adjusting payments based on clinician or practice-level performance is ill-suited to creating strong, coherent incentives to improve the quality and efficiency of patient care.

One problem is that a given patient's care often involves many different providers. Another problem is that clinician- and practice-level performance measures can be quite noisy. The fact that clinicians can choose the quality measures they report under MIPS also prevents MIPS from facilitating meaningful quality comparisons across providers. Consistent with these concerns, research on programs similar to MIPS, such as the Value Modifier program that preceded MIPS, provides little evidence that programs like these improve the quality or efficiency of patient care. MIPS is, however, creating significant administrative costs. CMS estimates that providers will spend $482 million reporting to MIPS in 2019. It is hard to justify incurring these costs for a program that is unlikely to meaningfully improve care.

Looking to the future, I encourage policy-makers to build on what is working in MACRA and discard what is not. A good first step would be to make MACRA's Advanced APM bonus permanent. Doing so sooner, rather than later, would maximize the bonus's im-

pact by encouraging providers to make long-term investments in APM participation today.

But it would be valuable to go further and substantially strengthen MACRA's incentives for participation in Advanced APMs, both by increasing the size of MACRA's incentive payments and by expanding these incentives to new categories of providers, like hospitals. These approaches would increase participation in Advanced APMs, broaden the types of providers with a stake in the deployment and success of these models, and enable CMS to go further in deploying versions of APMs that create stronger incentives to reduce spending.

It would be important to structure expanded incentives for Advanced APM participation in ways that do not increase Federal costs. For example, Congress could implement a budget-neutral combination of larger bonuses for Advanced APM participation and penalties for non-participation, similar to how Congress combined bonuses and penalties under MIPS. Policy-makers may also wish to consider eliminating the cliff in the Advanced APM bonus eligibility rules, which may soon cause some providers with significant engagement in Advanced APMs to miss out on bonus payments.

Turning to MIPS, I agree with MedPAC and a number of other experts that the best path forward is to eliminate MIPS. Most of MIPS's problems are unavoidable in a program that adjusts payments based on clinician- or practice-level performance. So even a reformed MIPS would likely struggle to create coherent and effective incentives to improve care.

If MIPS were eliminated, policy-makers could still retain targeted incentives for certain activities, like using a certified electronic health record or reporting to clinical registries. If MIPS continues, there are opportunities for improvement, although there are limits to what a reform in its program could realistically achieve. Potential improvements include standardizing the measures used in the MIPS quality category, replacing the MIPS practice improvement category with a targeted incentive for reporting to clinical registries, and replacing the MIPS Promoting Interoperability category with a simpler incentive for using a certified EHR.

Thank you again for the opportunity to testify. I look forward to your questions.

The CHAIRMAN. Let me thank all of you for staying within the 5 minutes.

[The prepared statement of Dr. Fiedler appears in the appendix.]

The CHAIRMAN. It is very helpful, particularly on a day like today when things are kind of erratic.

My first question is going to be just to Dr. Opelka, and the second one I will have for all of you to answer. The statute recognizes the value of data registries as they measure physicians on the things that they themselves identify as important to their patients. These data registries also provide timely feedback that physicians can use to improve. I am concerned about the statement in your testimony that these registries face challenges that have limited physician uptake.

Could you elaborate on the problems that have limited physicians' use of data registries and provide suggestions for how we can knock down these barriers? And if you are not prepared to offer

suggestions, maybe you can submit those in writing. But go ahead and answer as best you can now.

Dr. OPELKA. Thank you, Mr. Chairman. We will give you a more detailed response, because this is a very complex subject. We do firmly believe in registries. We run seven international registries to date. But putting them into the MIPS payment program or the MACRA programs is not actually taking full advantage of how you would leverage data for better care. And that is what we use registries for.

The biggest challenge we have out there, I can give you in a simple analogy. Imagine if every airport had its own air traffic control tower with its own data system and they did not talk to each other. We would have a mess up in the air. That is what we have with all these registries.

What we need is government guidance about how we actually set standards in key areas, how we define the data that enters registries, how that data actually is aggregated in a consistent manner so it comes in cleanly, how we can normalize and analyze that data together, and how we can represent it back out to patients and physicians as it is needed.

Right now, it is the Wild West. Everybody knows this is a great way of generating knowledge and helping better care, so everyone is doing it, and it becomes a burden on the EHR. It becomes a burden on the clinicians trying to use it. And it is creating cacophony.

Your success stories are in registries where there is a single source of truth, such as the ophthalmology registry or the cardiac surgery registry or the ACC registry where there is only one single source of truth. We find we can go there and find what we need for patients. When everyone out there creates their own version, we have a mess.

The CHAIRMAN. We will look forward to your submitting those suggestions. For the others—for all of you, I notice that all the witnesses focus on the need for changes to make these payment reforms more meaningful to physicians and more relevant to the patients they treat. What is the single most important change that would have the biggest impact in the effort to get patients the best care at the lowest possible cost?

Let us start with you.

Dr. MCANENY. Thank you, Mr. Chairman, for that question. I think the first and most important thing that we could do would be to have a continued positive update. If physician practices, particularly small and rural practices, are unable to maintain, they do not have any additional resources to be able to modify their processes and make changes. It is a little like trying to drive a car down the freeway and change the tires at the same time.

We are as busy as we can be taking care of patients. Making changes requires additional efforts.

Secondly, we need more opportunities for Advanced Alternative Payment Models. We believe that the MIPS APMs are a good proving ground to start with some changes and let physicians start working with that. So we would like to see expansion of that and stability in the program so that we have time to make those changes.

And third, I would say we need to continue the Advanced APM updates past the 3 remaining years, because without those incentive programs, there is very little reason for people to go through the large amount of effort. We could also streamline a lot of the reporting processes. Electronic health records are not good at sending data off to CMS or anyone else. They are adequate, barely, for treating patients one at a time. They are not designed for submitting data, and we would appreciate help from CMS and from Congress to help the electronic health record industry be more responsive to physician needs.

The CHAIRMAN. Thank you. Dr. Cullen?

Dr. CULLEN. And I would actually agree with that as well. You know, for the last 2 years, we have been educating our members about MIPS and Advanced Alternative Payment Models. We have been trying to get everybody into Advanced Alternative Payment Models as soon as possible. We have been calling MIPS "The Hunger Games."

But one of the problems has been that it has just taken so long to roll these out that we really have not had any members being able to really take advantage of them. We know that with advanced primary care, for every dollar you invest in advanced primary care, you save $13 at the end. And so if we are looking at ways to reduce costs, I think that is important.

And I would absolutely agree that our electronic records really do not do a good job of allowing us to really collate the data to be able to send it out. I am actually one of those practices that is in the low-volume exclusion, and thank goodness, because there is really very little way that our electronic record would be able to get the data to send out, much less actually perform, under MIPS.

And besides that, I mean, just the electronic records themselves really do not interact with each other. I am in a small town of 4,000 people. I have three record systems, none of which actually talks to the others. And so all these things are making it very complicated.

The CHAIRMAN. Okay. Dr. Opelka?

Dr. OPELKA. So very quickly, there are maybe four key areas. One is, create a value expression. Before you put a payment model on something, know what it is you are valuing. So what is the value expression for trauma care, for cancer care, for whatever kind of care you are delivering—create that value expression of quality over cost. So you are going to have to define both those key elements.

Second is the concept of asymmetric risk. CMS is stuck on this concept of "risk must be symmetric." People do not take symmetric risk. They want more upside gain than downside risk. It is good to have the risk and upside and downside, but asymmetry is how most businesses run.

The third is a true innovation center. CMS is trying to take the entire elephant in one bite, and you cannot implement on a broad scale. It needs the ability to do small innovation and even tolerance for failure. They are so afraid to fail, they will not take the necessary chances they need to truly innovate. So we need to change them to a true innovation center.

And last is this whole concept of data. It is not just EHRs. It is leveraging data, creating logical models using consistency, getting government standards to help us do this so that we can move forward.

The CHAIRMAN. Dr. Hines?

Dr. HINES. Thank you. I believe the best way to move the Medicare program toward value and away from fee-for-service is to promote the uptake of APMs and incentivize organizations to do that. That could be done through: (1) waiving the inclusion criteria that are in the statute that make it very difficult for organizations to qualify as an APM; (2) making the 5-percent bonus payment for Advanced APMs permanent, so that organizations have a predictable source of revenue to invest in the infrastructure, technology, and personnel necessary to deliver care using these new competencies; (3) timely access to claims data with benchmarking data on that as well, so organizations can see how they are doing compared to other similar organizations around the country; and lastly and most importantly, I would argue that we need to synchronize the rules across the various Federal ACO programs.

Currently, the rules change based on the degree of risk that you are taking, and so it makes many of our member organizations hesitant to take increasing risk when the rules change as you take increasing risk. So imagine you learn to play baseball running from first base to second base to third base. And then you get to college and they throw you in the game and they say, "Oh well, now we are running from third to second to first." The rules have completely changed.

That is the way that it feels and the way that the current rules and regulations are around the Federal ACO program.

The CHAIRMAN. Yes.

Dr. Fiedler, is there anything you want to add?

Dr. FIEDLER. I would just add that I generally agree that I think the most promising path forward to encourage more efficient and higher-quality care is to build on MACRA's incentives for participation in Advanced APMs. I believe that making the bonus payment permanent, as well as strengthening the incentives that exist, is a promising path forward.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you very much, Mr. Chairman.

Dr. Cullen, I am going to ask you a couple of questions that Robert Pear would be interested in this morning, because they are bipartisan, Democrats and Republicans, about good policy. They are about the future, and that is the whole chronic care area where he wrote the definitive story, where he said Medicare is not about acute illness, it is about chronic disease.

In this committee, Democrats and Republicans—and I would like for members, particularly our new members, to know it was bipartisan every step of the way, with Senator Isakson, Senator Portman leading on the Republican side, caring for people at home, advocating for the patient; Senator Warner, who just walked in, advocating for people at home, then-Congressman Markey, now Senator. But it was always a good policy, where the Democrats and Republicans could agree.

So, Dr. Cullen, I think the staffs talked to you about it. Tell me a little bit about your take on how we expand care for people at home who have these chronic illnesses, because it gives people more of what they want at a lesser price to the taxpayer. Portland has a wonderful program, House Call Providers.

My first question is, the Innovation Center has recently announced a new Primary Care First model, which I think builds on some of the good work that you are doing. I have heard from some physicians in Oregon that they think this is a path to more home-based primary care.

I would like to get the old band together again: Senator Grassley and I, Senators Portman, Isakson, Senator Warner, Senator Markey. I think you guys have some good ideas on it.

And particularly this morning, I want to hear about people working together. That is what Robert Pear was mostly interested in. What do you think?

Dr. CULLEN. Well, I absolutely agree with you that people would rather be at home and that chronic care management is really going to be the most important way, I think, that we can reduce costs overall, but also just making sure that people remain happy.

The Primary Care First program, actually, really does reward physicians for keeping people at home. And you know the reality is that the technologies now really allow us to do a lot more for people at home, and keep them at their home. And I can tell you that my patients would much rather not be in the hospital. I do home visits. As much as possible, I do try to keep them within their home, because that is where they feel most comfortable.

I think there is a lot of interest in the seriously ill persons' component of Primary Care First, and that is where there is actually added money available to really take care of people who are sick and keep them in the home. So I think that that is—both of those are really important directions to go.

Senator WYDEN. We will hold the record open—the chairman has been very generous in working with us—for people to have a few days. I would like to see in writing any suggestions you all have to make the model work when it comes to home-based primary care, what the Center for Innovation is talking about. That is the first question.

One other question, very quickly, Mr. Chairman. Dr. Cullen, I think you might have heard this other point I made about the chronic care point guard. I am just struck by how, particularly people who do not have Medicare Part C, for example, or something that coordinates their care—some of the ACOs, of course, do that as well—just get lost in this kind of blizzard of forms and paper. And as you know, the evidence shows that well over half of the Medicare spending is going to go for people who have two or more of these conditions, might have diabetes, cancer, or something.

I was teasing the chairman that I want to promote the "Grassley Always in Good Health Program," because somehow he and Barbara have the magic. But we have a lot of people with these two or more conditions.

So I would like to get the band back together again: Senator Warner and Senator Markey, and the good work of Senators Portman and Isakson, all the members of this committee—through

the whole chronic care debate, there was not one nasty, acrimonious word. People were just trying to figure out what the next steps were in terms of transforming Medicare.

So, what do you think about this chronic care point guard and trying to move ahead with a way to help people navigate this byzantine system, particularly if they do not have Medicare Advantage or some kind of accountable care program that pulls it together? What do you think?

Dr. CULLEN. So family physicians see ourselves as that point guard.

Senator WYDEN. Good.

Dr. CULLEN. That is exactly where we have positioned ourselves. And I have to admit I do not play basketball, but I understand the concept. And we do—that is really the whole idea because, otherwise, when people are going from specialist to specialist to specialist, their care is worse and their costs are higher.

We have found that with the chronic care management program that there are some impediments in that that probably need to be adjusted, because that has not fulfilled the promise that it has, just because it is actually very hard to make that program work unless you have a lot of beneficiaries.

So in my place, we do not have very many. And so just getting that program up and running has been difficult because of the impediment.

Senator WYDEN. Well, let us do this. My time is up. I would like to see anything in writing that you have. We acknowledged from day one that that was just the beginning. And particularly for the well over half of the patients who are in traditional Medicare, the problem you described is very real, and it is daily.

So give us a step-by-step, if you would, because I have talked to the chairman about this. And he has been very sympathetic to the idea, if there are some bipartisan ideas that are cost-effective.

Our goal is to really go step-by-step on building what is a modern Medicare program, as opposed to what we had. And I would very much like your specific ideas on exactly the point you made.

Dr. CULLEN. We welcome that opportunity.

Senator WYDEN. Thanks. Thank you, Mr. Chairman.

The CHAIRMAN. I am going to go vote. Senator Thune is going to lead the committee. Thune is the next one to ask questions. And then of the people who are here, it will be Brown and Warner. But if other people come back, there would be two or three ahead of you.

Senator THUNE [presiding]. Thank you, Mr. Chairman, Senator Wyden. Thanks for holding this hearing, and thanks to our panelists for being here today. I appreciate the opportunity to hear from stakeholders and how they think the shift to value-based care is going for their members.

An area that has always been important to me and to my State is ensuring that small and rural practices have the opportunity to succeed in this transition. The option to form virtual groups under MACRA aims to help with that. While it took some extra time for CMS to get the program up and running, I hope that we will see that it offers a helpful way for smaller provider groups to band together and increase their chances of success in MIPS.

Could our provider group panelists, perhaps Dr. Fiedler on the academic side of things, briefly share feedback that you have received from your members on how implementation of virtual groups has gone? Specifically, how do they identify fellow providers to work with, and are there any barriers to success at CMS that policymakers should consider? Dr. McAneny?

Dr. MCANENY. Thank you very much for that question. The AMA shares the disappointment that we have not had much uptake in virtual groups. I think one of the things that CMS could help us considerably with is to be more transparent about releasing the data.

We have looked at doing virtual groups, with my own practice participating in the oncology care model, and we found that getting the data a year and a half later makes it impossible to actually see how members of that group are doing. So having the existing clinically integrated networks work together and become some of these pooled groups would be very helpful. But we think that there are a lot of infrastructure costs that need to be done. So starting with groups that are already doing some of that may be helpful.

One of the concerns that physician practices have in trying to integrate with independent practices working together as a virtual group is the Stark and anti-kickback laws. We do not want to run afoul of those. Yet if we are going to be able to conserve resources, we want to be able to work together to create processes to have, say, the ancillary services part of the virtual group so that they cost less than if we send people to the local hospital to get a CT scan or something like that. The additional incentives and bonus payments that could be provided to help with the increased communication and coordination costs across a virtual group would be very useful.

Thank you.

Senator THUNE. Thank you. Anybody else? Dr. Cullen?

Dr. CULLEN. There was a lot of excitement about the program when it was first brought up. I have to say though that it has really proven to be very difficult to form these groups. And there is—I have not really seen a lot of interest among my fellow family physicians, even though, especially for rural physicians, this would be a great program.

I think that there probably needs to be a little bit more advertising or communication about them. But there is also a lack of multi-payer agreement on what that actually means as well.

Senator THUNE. So a year ago, CMS announced its rural health strategy with a stated goal of applying a rural lens to CMS programs and policies. CMS's willingness to acknowledge this issue presents a great opportunity to talk about the flexibility that rural providers need in order to overcome the challenges associated with taking on risks and implementing technology while managing an older and smaller population.

So, aside from virtual groups, what other suggestions have your providers offered in terms of how we can help ensure that success of rural providers in delivery system reform?

Dr. CULLEN. Well, first off, I think that paying them more would probably be helpful. And I say that because already there are many rural practices that are right at the very edge of survival, and part

of that is because of really the higher overhead that is associated with having a small rural practice, just because of the cost of actually running a practice.

And the second is just the complexity of the patients that we take care of and the difficulty with referrals, and with just being able to afford the IT infrastructure because we do not have somebody in town who is able to actually work on that, those systems. So I think that if you want rural providers to stay in business, I think paying them more is probably the best way to do that.

Secondly, I think reducing the complexity is really important. I think that is what we have already been talking about with MIPS. But the systems that most rural providers are able to afford really are not able to provide the data that we can then pass on to CMS. And besides that, a lot of times our systems do not communicate with other systems in those communities. Like I said, I actually have three different systems that do not talk to each other, and they are all located in the same building in our community.

Senator THUNE. Anybody else on that? Yes, Doctor?

Dr. MCANENY. Thank you very much. I would like to add to that that preserving the small threshold, the small volume exemption, would be very helpful because, if you think about those physicians and those practices that qualify for that, they are treating less than 200 Medicare patients. That is four a week.

So to a previous point that was made, even if you penalized all of those physicians by making them participate when they cannot make the scores because of all the problems Dr. Cullen mentioned, you would not produce very much money to put into this pool to give to the ones that are hitting higher scores. So, preserve that exception and make that available.

The second thing is the update. Having a positive update is so important, because we know that the cost of providing medical practice increases between 2½ and 3½ percent every year. Yet we are heading into a process where Medicare will give us a zero-percent increase every year. And that simply is not a sustainable thing. And the rural practices will be the first to feel that problem.

It is not just primary care. In my oncology practice, we have closed several rural clinics for exactly those reasons: that we cannot make ends meet because it actually costs more to deliver care per patient in a rural area where you have a smaller volume.

Senator THUNE. Thank you.

Senator Brown?

Senator BROWN. Thank you, Senator Thune. And thanks to our Senators Wyden and Grassley for this hearing. Thanks so much for your testimony and answering questions.

As you know, we passed MACRA to reward high-value patient-centered care. While MACRA is about physician payment reform, to be sure, our goal should be maximizing patient benefit. I know all of you, from your comments, agree with that.

It is clear we have not done enough to ensure that patients' voices are a part of the process and that patients are benefiting from these changes. NIH created the Patient-Focused Therapy Development tools and systems dedicated to engaging patients throughout the translational science process. FDA has implemented a Patient-Focused Drug Development model to help ensure

that patients' experiences and perspectives and needs and priorities are captured meaningfully during drug development and review. My question is for you, Dr. McAneny.

Two questions: do you believe CMS and Congress are doing enough to ensure representation of the patient voice throughout the development and the implementation of MACRA, first question? And second, what more can your physician organizations and CMS do to ensure that patient needs and priorities are kept at the center of health-care delivery? If you would try to answer those together, thank you.

Dr. MCANENY. Thank you, Senator Brown.

It is a difficult method to try to collect patient-reported outcomes because patients who are sick are too busy being sick. I am a cancer doctor. They do not have the energy to fill out forms. And for example, in the oncology care model, they send out an 84-question document that patients are supposed to fill out, which they do not.

So what we have found works better and what the AMA has been proposing with this is to make sure that the patient advocacy organizations are heard—and we talk to them and convene them in multiple of our sessions—but also to recognize what patients need through examples like the patient-centered medical home.

We did this in oncology, and our patient satisfaction scores were in the high 90-percent range because you give patients the help they need when they need it at the lower cost side of service. And in addition, we saved about $2,100 a patient, which was pretty good.

So it is possible to do that, and by incorporating what patients want and patients need and their values into this, you can direct their care and avoid care they do not particularly want. And we continue to work more with that.

One of the ways that we are trying very hard to involve patients from the AMA standpoint is to recognize that there are a huge number of Americans who have pre-diabetes and do not even know about it, and have other chronic diseases that are not well managed, and we recognize that that takes a team of people to work on those. So we are focusing on diabetes, pre-diabetes, and hypertension to try to look at the chronic diseases that Americans have said they wanted treatment for.

We also continue to work for access to care, because what we hear from patients is, this is the most important thing for them, to have continued access to care.

Senator BROWN. Thank you.

Dr. Cullen and Dr. Opelka, I will ask you a question jointly as my last question. In each of your testimonies you mentioned the importance of patient-reported outcomes. We obviously should be measuring whether or not we are paying for care that is in line with the patient's goals. If you could comment, how many of the existing 424 measures in MIPS consider the patient voice in their priorities? Dr. Cullen and Dr. Opelka?

Dr. CULLEN. I am actually not sure I can answer that. But there is a saying in family medicine that it is not patient-centered until the patients say it is.

Dr. OPELKA. In the surgical space, we do not have any. We, ourselves, run our own patient-reported outcomes within our database

to inform our members. But they are not part of the payment program.

Senator BROWN. Okay. Thank you. Thanks, Mr. Chairman.

Senator THUNE. Thank you, Senator Brown.

Senator Roberts?

Senator ROBERTS. Well thank you, Mr. Chairman.

I would like to echo the sentiment shared by many of our witnesses this morning that, while MACRA is not without its challenges, it certainly was an improvement over the sustainable growth rate payment system and the many doc fixes passed by Congress over the years.

I remember, personally, we would promise the docs and everybody else involved in the rural health care delivery system, and for that matter, the State of Kansas, "Yes, we will fix it." And each month would go by, and finally at the 11th hour and the 59th minute, we would come up with something—never enough, never enough. I never understood why we could not do that the first thing in the Congress so we had a better system.

MACRA was a significant step toward improving quality for providers and, more importantly, patients going forward. But I have several concerns about how the law affects small and rural practices. I know that has been emphasized by most of you.

The Merit-based Incentive Payment System, MIPS, is set up to rate providers based on requirements that are often simply too burdensome for these practices. And that is probably an understatement. These providers already face higher expenses and limited resources and lower patient volume, which is often not adequately reflected in MIPS. I appreciate the actions that have been taken to offer these practices exemption and flexibilities from MIPS. However, much more work needs to be done in order to make meaningful improvements for these providers and their patients.

It is terribly important to ensure they are not overburdened. We should now also aim to incorporate small and rural providers and their quality improvement systems by accounting for the unique challenges they face. Both providers and their patients deserve to be included in Federal efforts to improve health-care quality without being penalized by these programs simply because of the geography or size of the practice.

As co-chair of the Senate Rural Health Care Caucus, I, along with my colleagues on the caucus, sent a letter to the National Quality Forum in 2016, back then, requesting that the NQF convene a rural Measures Application Partnership—the acronym for that is MAP—to develop quality measures that are relevant to these rural practices. I was very pleased in August when the rural MAP published the first-ever set of rural-relevant quality measures. But I believe, while this is an important step, including all providers into quality programs in a way that is both meaningful and appropriate would be the best course.

Dr. McAneny, you have a situation in Iowa. I hope you are not underwater where you live, and I hope you can get through all of that. We are waiting for that in Kansas. But you mentioned in your testimony that rural and small practices, in particularly our very small rural communities, tend to have lower MIPS scores compared to the national average. How would more appropriate quality meas-

ures help level the playing field? Would other improvements beyond changes to quality reporting be necessary? As a tip-off, I think that answer is "yes."

Dr. MCANENY. Thank you very much, Senator.

And I am actually in New Mexico, and we would love to have some of that extra water from Iowa. As we look at the very specific issues that affect rural patients, what we find is, because they have less discretionary income often, we fall into the category of the social determinants of health. And holding physicians accountable for those social determinants makes things incredibly difficult. I know it from my own practice, which is rural, that we end up with patients whose outcomes are very much affected by food insecurity, by transportation issues, and other things that we are not currently allowed to help solve.

If we try to provide transportation through the practices to get to care, for example, we are at risk of being guilty of inurement and offering something of value. So releasing some of the laws that constrain us from being able to band together with other rural practices to be able to provide these services for patients would be very, very useful.

Having rural practices, small practices like mine, work to try to put the data in for MIPS takes a huge amount of time and effort. I decided as AMA president that I would set an example for everyone and prove that a rural practice could do this. I scored 100 on MIPS. My increase was 1.88 percent. And after the adjustment that occurred after that, it lowered that increase to where the entire change that I got was $34,000.

When I added up how much I had to pay my EMR vendor to submit that data, when I had added up everything that I had to do in terms of paying staff overtime to make sure the data was accurate, I lost $100,000 to score that perfect score. So we need to modify that. That is, I think, a great example of why the lower-volume practices need to be kept out of this process so they can continue to use their resources on patient care.

And we need to streamline this entire process so that we can submit the data, hold ourselves accountable for delivering the quality of care that our patients deserve, but do it at a lower price tag.

Senator ROBERTS. Thank you.

My time has run out, Mr. Chairman. I would only point out that when you score 100, it is like all of a sudden the referees, the people who wear the stripes in the basketball game saying, "I am sorry. You only scored 80, and you lost the game."

Dr. MCANENY. I lost.

Senator ROBERTS. I yield back.

Senator THUNE. Always very perceptive and insightful——

Senator ROBERTS. Thank you.

Senator THUNE. Senator Warner?

Senator WARNER. Thank you, Senator Thune. And I guess that would be one way to describe Senator Roberts.

Thank you all for being here. And I think as you heard from the chairman and the ranking member and all of our questions, this is actually an area where I think we all agree. It feels like, while well-intentioned, we may not be getting the results we are looking for. I have a lot of small rural providers as well.

I have three questions I want to try to get to, and I recognize that we have focused on only part of the panel. I think I will start with you, Dr. Cullen.

You know, I am interested in the Physician-Focused Payment Model Technical Advisory Committee, PTAC. It seems like they have done some good work. I have been particularly interested in some of these physician payment systems, particularly around advanced directive, end-of-life, advanced care models.

It seems like while—again, well-intentioned—CMS has not been very good about actually implementing these models. What can we do, or is this where we should—do we need legislative change here? Do we need haranguing on CMS? I would love to hear, again, any of your suggestions. And if we could fairly quickly, since I have a couple other questions.

Dr. CULLEN. The big problem with the Advanced Alternative Payment Models is that they have taken a really long time to roll out. That has not really been the fault of PTAC, because we had ours approved back in 2017. Somehow in that process, getting it actually rolled out has proven difficult and much longer than we expected.

Dr. MCANENY. I would like to add that having the CMMI able to do pilot projects might be very useful. And yes, they evaluate a lot of good programs that have been submitted to them. But if we can get some of the pilots enacted, that would be very helpful.

Dr. OPELKA. The PTAC is going through an enormous amount of work in the conceptual modeling, and it is fantastic. It then fails when it gets to the Innovation Center because it is trying to do broad-scale innovation rather than narrowing it down. Let us test it. Let us see if we can do this implementation.

And how do we partner? There is really—it goes inside the government, and it gets lost in a big swallow. It needs to actually be much more nimble if it is truly going to be innovative, and it cannot be afraid to fail, and then modify, and change, and grow.

There is a lot of, "Oh, we just cannot fail with this because we are trying to do a big implementation."

Senator WARNER. It seems, though, that this might be an area where you do not necessarily need a legislative change, but maybe a group of us from the committee to kind of put the pressure on CMS to say, "We gave you these tools." We need to try and recognize, and maybe get us on record as saying, "Try, and we realize you may have some failures." And if we are then on record, then we cannot complain when the failures come back. But I think, as a former venture capitalist, you have to have that mind-set.

Dr. Fiedler, on the merit-based incentive program, in your testimony you said, "Let us just eliminate it." I am reluctant to think that—I know it has been not appropriately implemented. But is there—are you fully in that it is not worth trying to reform, retweak? Do you think elimination is the only option?

Dr. FIEDLER. So, I am not optimistic about what can be achieved through reform. But I do think there are options to improve on the status quo. I think there are improvements we can make in the quality domain to ensure that clinicians are not incentivized just to select the measures that they think they are going to be able to

get the highest score on, rather than the ones that are most meaningful to their patients.

I think there are opportunities to simplify the Promoting Interoperability category to get what the public—what we sort of want out of that category, which is greater take-up and anchoring of the certified EHR standards, not a box-checking exercise about, you know, are you using the record in this particular way that CMS thinks you should?

And I think we can improve the practice improvement category by transforming it into a targeted incentive for specific high-value activities, rather than the sort of grab bag of 100 activities we have today.

Senator WARNER. I would love to see—perhaps in a written response—some of those ideas laid out.

Let me lay out one last question. I am probably not going to get a chance to get all of you to respond. But for the record, you know—I failed to mention interoperability.

I was a telecom guy before I was in politics, and we should have seen this train coming in terms of the need for interoperability and all of the promise that we so over-promised on EMRs—and so under-delivered, I think a lot because of the lack of interoperability.

But on a broader basis, everything—so much we are talking about in terms of pricing and some of your comments already about the requirements to try to get all this data, we are going to move towards a more data-centric system.

But wearing my other intel hat, we are seeing enormous vulnerabilities coming from cyber. And I have put out, in a sense, a request for ideas and proposals across the health-care field. And huge uptake—and Senator Thune plays a leadership role on this on the Commerce Committee—huge, huge uptake, but the vulnerabilities we have seen, we are already starting to see with some of the ransomware against hospitals. But the ability to hack into individual docs' systems and others, I would hope that you could all come back to me with your perspectives on how we continue to take full advantage of this data-rich environment, but also not repeat the failure on EMR by not having interoperability.

We may repeat the same if we do not build in basic cybersecurity hygiene and standards as we continue to accumulate this data. And I just think it is a huge vulnerability.

I know I am over time, so I do not want to—I am over time. So maybe you could answer Dr. Cassidy on part of that question.

Thank you, Senator Thune.

Senator THUNE. Thank you, Senator Warner.

Senator Cassidy?

Senator CASSIDY. Thank you very much.

First, I do not want to be pedantic—Dr. McAneny, it is nice to see you. I do not want to be pedantic, but let me just point out that in your testimony you speak about these small practice MIPS having a mean score of 75, but a median of 63. It tells me that some practices do very well. It is just that most practices do not—that kind of difference between mean and median.

Now I raise that, again not to be pedantic, but are folks familiar with the direct contracting model options that were released? Dr. Cullen, you would be.

And so let me just—as quick background, when I was on Energy and Commerce on the House side, Mike Burgess and I had this concept that small independent practices—small practices within an independent practice association—could go to a two-sided risk directly contracting with CMS.

Now if we focus on outcomes, not upon measures—so that is the good thing about it. And the reason I kind of develop it all this way is that Dr. Hines points out that MIPS excludes small practices. You make the case that it is probably necessary because of increased cost of compliance. But when I look at that difference between mean and median, it looks as if small practices can do it, it is just that a lot do, but just a lot more do not.

So having said that, Dr. Cullen, to what degree do you think that small practices can participate in this direct contract model? And do you think this would be a way to incentivize that smaller practice to go into a two-sided risk arrangement where hopefully they benefit from the upside?

Dr. CULLEN. First off, I am excited to try it because it has rolled out in—Alaska is one of the pilot States under Primary Care First. So I will be able to tell you a little bit more, maybe in a year.

One thing about the two-sided risk is that I do agree that we need to make the downside risk fairly minimal. And I say that because, again, a lot of practices in rural areas and small practices are really right at the margin at this point.

And so, if it is a large two-sided risk——

Senator CASSIDY. Now, let me stop you for a second. There is a group of physician-run MA plans, and their physicians do better financially. They actually have smaller panels than does the regular Medicare-focused practice.

And the guy who runs it says, "I just go to a small practice and I say, 'Was there one patient who you hospitalized last week that you did not have to?' 'Oh yes, I could have brought them here instead of the ER, but I was just slammed.'"

If you had not admitted that patient, you would keep the savings. So I say that knowing that there are some tight margins, but that there are practice decisions that we can make as practicing physicians that can lower costs with the benefit accruing to us. Would you agree with that?

Dr. CULLEN. Absolutely.

Senator CASSIDY. So it would increase those margins.

Dr. Hines, any thoughts on all this?

Dr. HINES. Yes, thank you. I just want to point out, because it has been brought up a few times, about small practices and MIPS—and I think Dr. McAneny's example of scoring 100 is a good example of why we should do away with the exclusions and be able to have the funds to be able to reward the practices that are doing a good job.

And let us not forget that there is funding in MIPS for the small uninsured and rural support initiative to help these smaller practices be able to report on quality and be able to have the help that they need. And MIPS is really an on-ramp towards value.

And AMGA's position on this is that we should be expanding this so that more and more providers are able to——

Senator CASSIDY. Because I have limited time, can I get you back to what I was asking: this direct contracting model in which IPAs could go at risk?

Dr. HINES. So I think that it, in theory, is a great model. I think the devil is in the details. This idea of having a per-capita reimbursement but having patients have total choice of care and be able to go anywhere they want——

Senator CASSIDY. It could be a prospective assignment as in an MA. It would not be an ACO where, after the fact you decide where people got their care. It would be a, no, you are going to be my doctor sort of thing.

Dr. HINES. And I think as long as there are those assurances in there, and that there are some limits to the network so that you can promote patients to go to physicians who have been shown to be high-quality and low-cost, I think it has the potential to be successful, yes.

Senator CASSIDY. Dr. McAneny, any comments?

Dr. MCANENY. Yes; thank you for that question.

First of all, I think that having the prospective payment is key, because my practice had the $100,000 to invest to get that perfect score, but many small practices do not have that resource. And going through the process to get technical assistance does not substitute for that. So having a prospective payment come out first is great. I also think this is a great opportunity for us to do a test for this and see.

I think we need to scale risk according to what the practice can manage. If you are a small practice, promising a job to another nurse, a salary with benefits, is a significant financial risk. So I think we need to look at that very carefully. We do not want to put so much risk on a practice that if they do not succeed, we lose the interest——

Senator CASSIDY. I accept that. I am out of time.

I will make a comment, though. Going back to this physician-run MA plan, the paradigm has always been, see as many patients as you can to cover your overhead.

This is a different paradigm: actually give higher-value care, and your margins actually rise, even though you see fewer patients. And I do think that there is going to be an emotional and intellectual adjustment.

We are out of time, and I will give it back to the chairman.

The CHAIRMAN. Senator Whitehouse?

Senator WHITEHOUSE. Thank you. First, let me thank the chairman for having this important hearing. And let me say how glad I am that Senator Cassidy is here while I have the chance to ask my questions, because we have worked well together in this area, and I hope to continue.

I am going to ask you to answer these questions in writing if you care to, because they are fairly complicated. Consider them an invitation.

Before I ask the questions, I just want to make one observation, which is that CBO does rolling projections of what the total Federal health-care spend is going to be. And their most recent projec-

tion is down over $4 trillion over 10 years from what it was projected to be 10 years ago. So something big is happening out there. We do not understand what it is. But $4 trillion is a lot of money to project in savings.

So here are my questions. The first has to do with ACOs. Rhode Island has two of the best provider ACOs in the country, Coastal Medical and Integra. They are doing very well.

CMS has not always been their best friend. There have been a variety of efforts at CMS that frankly would have been very damaging to the ACOs. My view is that you feed the lead dogs. They should feel rewarded and supported. And very often they feel challenged and almost unwelcome. You also invest a little bit more than you do in the final product in a prototype. So for a whole bunch of reasons, I think we reward the really good performers and figure out what they did, and figure out how you propagate; that is a better strategy than trying to extract as much savings from each one as you can at this early stage while we are still developing the prototype.

One of the problems that the ACOs face is a leveraging problem. If they are going to bear risk, they bear risk on the entire cost load of their patients. But they only control 10 to 15 percent of their patient cost. The rest is specialists, pharmaceuticals, hospitals—people over whom a provider ACO has no control.

So I think that is something we need to try to figure out: how you prevent them from having to not take risk because they feel so leveraged. So that was question one, supporting provider ACOs, feeding the lead dogs. What can we do better?

The second has to do with end-of-life care. Whether you call it "end-of-life" or "advanced care" or "palliative care" or whatever, there is a space in there where—with respect to Dr. Opelka's comment that we need microcosms for innovation to sort of test the innovation model and move forward—I think that ought to be one.

There is a big group called C–TAC, Coalition to Transform Advanced Care, that is working in this space. And I think that there is a space there where some of the Medicaid rules, if you are actually dealing with this population as a population, become counterproductive. And Adam Boehler is being helpful in trying to solve that problem, but it would be helpful to have your thoughts as well about this population.

It is the "2-night, 3-day" rule. It is the "patient in the hospital for respite care" rule. It is the "you cannot get home care services unless you are homebound" rule. There are a whole bunch of things that, perhaps in the abstract, make sense, but do not once you start managing this population.

Third, the electronic health record/health information exchange interface for doctors. Senator Cassidy and I just had to file a bill. We did not need to get it passed to get some of these EHR providers to change their behavior about the gag rule. So I think there is actually the prospect for pretty strong bipartisan signaling out of this committee where there are problem areas.

I think we all understand that the business model of some of these providers—not the medical providers, the data services—is to try to encourage people to adopt their own program by being less interoperable than they should be. They actually have a counter-

incentive to the interoperability that will serve patients. And we need to figure out how to fight our way through that.

Last question, or last point for your response, is that it strikes me that one of the areas we have not engaged in very effectively yet is at the State level. There was an effort at one point by CMS to go and try to impose programs by its regions. Nobody cares about its regions. There is nothing real about its regions.

What is real are States. They have Governors. They have medical associations. They have health departments. They have Medicaid programs. And if we could work together to figure out a way to reward States for better outcomes, as well as individual practices, I think all of that State-based machinery can then be put to work to help solve these problems.

At this point, other than the Medicaid programs trying to reduce cost, I do not think we have engaged the States at that level. So if you were to do a Medicare penalty for States that are outliers in terms of quality versus cost, I think the Governor, the head of the medical society, the health director, and the Medicaid program director would all be in the room the next day saying, "How do we avoid this?" And we need to provoke that kind of activity at the State level.

So those are all for responses in writing. I hope this is a healthy dialogue, and I think there is a lot of bipartisan interest.

And thank you, Mr. Chairman, for having this hearing.

The CHAIRMAN. Yes.

If Senator Hassan is ready—if you are ready, you are up next. If you are not ready, I have one question, but I think——

Senator HASSAN. Why don't you ask your question, and then I would be happy——

The CHAIRMAN. Okay. For any or all of you—but do not take a lot of time away from Senator Hassan to get too deeply into this—I take special interest in making sure that there are physicians to care for people in my rural areas, and there are a lot of rural areas more rural than Iowa. But we have plenty of them.

And rural physicians should have an opportunity to participate in the Alternative Payment Models. What can be done to create such Alternative Payment Model opportunities and give physicians in rural areas the best chance to succeed in them?

Dr. MCANENY. Thank you very much. I think the MIPS program is a way to start with that, with MIPS Advanced APMs. The medical home can be done by very small practices. It is not at this point a payment model, but it is a MIPS APM. And so that is very useful.

We are hoping that some of these pooled processes may work for that. But the first step has to be to give those practices the resources to be able to have the time and flexibility to innovate. And that means that will not happen if we have a zero-percent update for the next several years for those practices that are still in MIPS. It is a process, and they cannot stop taking care of the patients of today to think about how they are going to manage the patients of tomorrow, and in an alternative method.

We promote the PTAC idea of starting out with, how do you want to deliver the care, and then adapting the payment model to

fit that, instead of the current method of creating a payment model and then telling the physicians to adapt their practices to that.

The CHAIRMAN. I am just going to hear from Dr. Cullen and then go to Senator Hassan—since you are in a rural area.

Dr. CULLEN. Well, the American Academy of Family Physicians' Alternative Payment Model I think is really going to work in a rural situation. That is something that I have been watching really closely, given my situation. But as a prospective payment with significant upside risk, I think that that is something that will help significantly in rural practice.

The CHAIRMAN. Okay.

Senator Hassan?

Senator HASSAN. Well, thank you very much, Mr. Chairman, and thanks to you and the ranking member for having this hearing. And to the panel, thank you for your testimony. And to say that the Senate's voting practice this morning is disruptive is an understatement. So I appreciate your patience with that.

Dr. Cullen, I wanted to just start by following up on what I think has been a little bit of your earlier testimony. New Hampshire also has its share of rural hospitals, and I am very interested in a number of the issues that you have talked about.

But could you speak a little bit more to the specific challenges that rural hospitals and providers face complying with these reporting requirements, and talk a little bit more about how it impacts patient care in rural communities?

Dr. CULLEN. Well, the biggest impact is if the hospital or the providers close or leave.

Senator HASSAN. Right.

Dr. CULLEN. And unfortunately, we have lost almost 100 small rural hospitals in this country in the last 10 years, which has had a huge impact on maternal and infant mortality and other factors. So this is an enormous impact.

Senator HASSAN. Right.

Dr. CULLEN. As far as why, a lot of it has to do with the ability to do the reporting. We just do not have the sophisticated systems that allow us to do the reporting or an easy way to do that. And part of that is because of the costs that are incurred just in buying those systems.

Part of it is just the support. And then the third thing is that oftentimes I see that there is an idea that things are easier in rural communities and that they are cheaper. And it is just the opposite.

We take care of a whole range. In my community, we do full spectrum OB, which means we deliver babies, we do C-sections, we do surgery, we cover the ER; the pace is very intense. But being able to find the pool of people to work in the clinic or in the hospital is also extremely difficult. And so all of those raise costs dramatically.

Senator HASSAN. Okay. Thank you.

I wanted to ask each of you to comment, if you could, on an issue that, again, is near and dear to my State, which is the opioid epidemic. MACRA provides an incentive payment for providers who improve their tracking and reporting of quality measures related to opioid prescribing, treatment agreements, follow-up evaluations, and screening of patients who may be at risk of opioid misuse.

The question that I have is for anyone of you who might have insight into the issue of substance use disorders. Specifically, have these new reporting requirements had an impact on reducing opioid misuse, and are there ways we could improve the collection and use of this data being reported in order to have a greater impact? Anybody want to—Doctor?

Dr. CULLEN. Our clinic does provide medical assisted treatment. We do a fair amount of work with the opioid use disorder. We would be doing that regardless of the MIPS measures, frankly. And that is just our task.

As far as capturing the data, I think the hard thing is that—again, this is an area where it is very hard to distill that down to individual data points, because opioid treatment disorder is something that really requires a full-court press with counseling, physical therapy—we actually use acupuncture as well as medication-assisted treatment.

Senator HASSAN. Right.

Dr. CULLEN. It is something that is very labor-intensive.

Senator HASSAN. Thank you. Yes, Doctor?

Dr. MCANENY. Yes, from the AMA standpoint, we have had an opioid taskforce looking at this for many years now, since 2014, because we recognize this. And we have done a lot of educational processes that have decreased the amount of prescriptions only to see patients then shift to street drugs to get their medications that they want.

Having the opioid use treatment processes as a quality measure in MIPS so that people can score for that would be, I think, a helpful process for that, and having the prescription drug monitoring programs more user-friendly, and also recognizing team-based care as opposed to one-physician one-patient all the time.

Senator HASSAN. Right.

Dr. MCANENY. That is not how we practice anymore. It would be very useful along those lines. And having the processes in place so that there are more options for treating people who have opioid use disorder—many communities, particularly, are severely impacted. Rural communities do not have anyone who can help with that disorder. It needs a full-court press.

Senator HASSAN. Thank you.

Dr. Hines?

Dr. HINES. Yes, I would just add that the opioid epidemic, I think, is an area where the model of care that is promoted by AMGA can be quite successful, because we are all about coordinated, integrated care. And as has been mentioned already, in order to treat opioid addiction, just like in order to treat chronic diseases, you need to make sure that you have the full spectrum of services available for patients. And it is often helpful to do that in one place.

So I think that having measures around opioid use can be helpful, but I think it is more just the calling of physicians to realize that this is a problem, and the best way to treat that is in an integrated, multidisciplinary way.

Senator HASSAN. Thank you. Thank you all very much, again, for your testimony, and for your expertise and work.

Senator ROBERTS [presiding]. Senator Carper?

Senator CARPER. We apologize for this—the way things are being conducted. When Senator Roberts and I are in charge of this place, this will not happen. [Laughter.]

So thanks for bearing with us.

But thank you for being here. Thanks for your testimony and responding to our questions.

I am interested in hearing about roughly how many physicians and health-care providers participate in Medicare, but I do not know if you all have any idea about that. Any thoughts on that? How many physicians and health-care providers actually do participate in Medicare? Anybody want to venture a guess?

Dr. MCANENY. I can get you the exact numbers of people who do participate in——

Senator CARPER. Can you give me their names and addresses? [Laughter.]

Dr. MCANENY. CMS is supposed to have that registry.

Senator CARPER. Okay. Well, we will ask them.

Dr. MCANENY. But I think that the vast majority of physicians do, which is always an interesting thing given that Medicare does not pay for the full cost of care. It is just that as physicians, when you are taking care of a patient, they age into Medicare, or your colleague asks you to see a new patient who is on Medicare. You think, this is a patient who needs me, not, is this patient going to pay their own way, because we know that they do not under Medicare.

Senator CARPER. All right.

Yes? Is it Cullen or Cullens?

Dr. CULLEN. Cullen, thank you.

Senator CARPER. Hi, Dr. Cullen.

Dr. CULLEN. Family physicians, and it is well over 90 percent, accept Medicare patients.

Senator CARPER. All right. Thank you.

All right. Anybody else have anything else?

Dr. HINES. I believe the number is 1.5 million physicians.

Senator CARPER. All right. Thank you. Are you rounding? [Laughter.] Okay. All right.

A follow-up question: what can we on this side of the dais be doing in Congress to increase the number of physicians who are participating in these Alternative Payment Models, maybe more quickly and perhaps even more effectively?

Dr. HINES. Sure. Maybe I can start with that.

So I think the best way to do that is to promote APMs. I think that the APMS are the best way to move the health-care system toward value and away from a fee-for-service system that really incentivizes transactional-based care.

And in order to promote APMs, we need to eliminate the thresholds that are preventing many groups from being able to become APMs. We need to make the 5-percent Advanced APM bonus permanent so that groups have the dependable revenue to be able to invest in the personnel, resources, and technology to succeed under value, such as the chronic care point guard that Senator Wyden was mentioning.

And also, we need to make sure that we synchronize the rules across all of the different ACO programs so that when folks learn

how to take risk on an upside-only program, those same rules apply to the downside risk as well, so you are not learning under one set of rules and then performing under another.

Senator CARPER. I am not going to ask everybody to go—anybody agree with anything that he just said?

Go ahead, Dr. Cullen.

Dr. CULLEN. I think the other thing is that it would be better to roll out these programs more quickly and also have them available in more geographic areas. One of the problems with the rollouts in the past is that they have been actually very small areas, and so large parts of the country have not been able to take part in any kind of APM, much less an Advanced Alternative Payment Model.

I think that if we could rapidly ramp up those and expand them to more geographic areas, that would be useful.

Senator CARPER. Thank you. I appreciate it.

Dr. OPELKA. So thank you very much. For us—as the American College of Surgeons—when we look at this, we have been trying to actually fit something into a payment model. And what we really need to do is define the value of care we want—trauma care or cancer care—and then for that value of care, what are the elements that we need to afford it? And then, how do we put that into a risk model that has asymmetric risks, where there is more incentive to take the risk and there is less risk that you will go bankrupt if you take that risk? But you need upside and downside risk.

Senator CARPER. One last quick question, and that is, what Alternative Payment Models are best suited for improving end-of-life care and treatment for opioid addictions? Any thoughts?

Dr. HINES. So, perhaps on the end-of-life care, Crystal Run Healthcare is involved in the oncology care model. And one of the things that we have learned in that model is that we are significantly underutilizing end-of-life care.

And we have really put together a team of experts within our organization to have those difficult conversations earlier, so that less futile care is provided and less patients are dying in ICUs, but rather dying at home with their family around them.

And it is really an opportunity to participate in these programs that allows you to see what your data is around that and how you can do a better job for your patients and your population.

Senator CARPER. Dr. Cullen again—go ahead, ma'am.

Dr. MCANENY. Thank you. I am a medical oncologist, and I am participating in that. We also have an oncology medical home process as an Innovation Center award. And what we found was that, when patients know that you are there for them all the way through the course of their illness, and you have that continuity of care—and basically oncologists function as the primary care doctor for the subset of patients with cancer—then they trust us.

And as a byproduct of saving money by keeping them out of the hospital and offering those things, we saved a significant amount of money on end-of-life care because of the trust and the relationship that was established. So I think that is a very important part.

The opioid issue, you know, to have that requires an entire team-based effort as well, and I think that is part of the new primary care models that are coming out. I will defer that to Dr. Cullen.

Senator CARPER. All right. Thanks.

Dr. Cullen, my time has expired. I am going to ask you to respond for the record, if you would.

And thank you all very much for being here and for your testimony. Thanks.

Senator WYDEN [presiding]. Okay.

I have a question, and then I want to make sure that all the bipartisan staff are acceptable with our wrapping up.

Apropos of rural areas—and this has been a great interest of the chairman, of myself, of many Republicans and many Democrats. We have a question about how these rural areas are going to fit with respect to innovative payment models. In other words, everybody talks about them. This is practically a gospel of health-care policy. You have a lot of Senators here, as I said, both sides of the aisle, who care deeply about small practices, rural areas, underserved areas, and we are trying to figure out how they are going to fit in this brave new world.

So I am going to allow any of you to comment on it. And then I would like to ask the staffs on both the Democratic side and Republican staff to make sure that they are okay after this with their members wrapping up, okay?

Yes, Dr. Cullen?

Dr. CULLEN. So I think the most important thing is making sure that these Alternative Payment Models pay adequately for the physicians to stay in business, because that is one of the big issues. A lot of practices are really at the margins for survivability.

I really am very in favor of Alternative Payment Models. I am very excited about the possibility of trying it, but it is going to be the—you know, the devil is in the details. It is how much is actually going to be part of the prospective payment that I think is going to be—and what is going to be upside and downside risk is going to be the real key.

Senator WYDEN. Any others? Dr. McAneny?

Dr. MCANENY. Thank you.

So I think there are several things that can be done for this. First, when a small community of physicians wants to get together and try to provide services that are less expensive and more timely delivered, they are impeded by the Stark and anti-kickback rules. They cannot get together and say, "Gee, if we as a group purchased a scanner, we could charge a third of what is charged at the local hospital." And they cannot get together to do those kinds of things. So adjusting the Stark and anti-kickback rules would help immensely.

To recognize that the rural areas often have more of the social determinants of health in terms of food insecurity and housing insecurity, et cetera, is something that needs to be accounted for in the attribution. That may be a part of why a lot of rural areas score lower in terms of their hospital quality and physician quality, because the social determinants are such a major input.

Then stability and some up-front payments—it takes, basically, money to invest in creating a new delivery system, to hire a new nurse to do the patient education that is needed or the outreach to find that patient who needs an intervention. And without the up-front, firm commitment to increased resources, you cannot guarantee someone that they will be able to do that.

And third, the other impediment is the data. When we get data from CMS, it is a year or a year and a half later. It is aggregated data. It is impossible to manage that data in a way that I can figure out what I could do differently in my practice today so that my next reports come out better. And simplifying and clarifying the data that is delivered from CMS and making it happen in a more timely manner, would be great.

And stabilizing the payment system—if you do not know that your practice is going to be there next year, it is hard to spend a lot of money worrying about innovation.

Senator WYDEN. Anybody else? And then we will probably wrap up. Yes?

Dr. FIEDLER. I think there are opportunities to think about how we improve measurement in ways to make sure that providers in rural areas are being compared against providers that are providing care in similar circumstances. So you could think about approaches that would compare providers against either other providers in their own region, or other providers in geographically similar regions.

The various ACO programs have taken steps in that direction, but I think there are opportunities to go further beyond ACOs.

Senator WYDEN. This would be another area where I think it would be very helpful for you all to use the time the chairman allows to get us any responses in writing on this. You know, there is no question with respect to, sort of, the nuts and bolts of getting from here to there. In other words, you do not quickly move a $3.5-trillion health-care system, which, as we know, has given short shrift to rural America in many respects like this.

So I am very sympathetic to these kinds of transition areas. It is like, Dr. Cullen, when I talked to you about the CHRONIC Care bill, we never announced that the legislation was the end of the debate. We said, "This is the beginning. This is the beginning."

And Robert Pear, on this sad day, was the guy who figured that out. So your ideas are welcome. You have Democrats and Republicans here aligned with you.

As you can tell, the members are just juggling. And on behalf of the chairman, we just want to say "thank you" to all of you for your participation. It is hard to get to Washington, and the chairman wants to make it clear that he appreciates everybody's expertise and coming.

And on behalf of him, I would ask that any member who wishes to submit questions for the record to the Finance Committee, please do so by close of business on Wednesday, May 22nd. And as we have indicated, there is a lot of interest in rural health care.

And chronic care is almost my passion now, because I think this is the future of health care. And this committee figured that out. So we really thank all of you.

And with that—and I want to check with both the Republican and the Democratic side—I believe that there is a consensus, because of the schedule, that we are going to wrap up. And with that, the hearing is adjourned.

[Whereupon, at 11:24 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF JOHN S. CULLEN, M.D., FAAFP, PRESIDENT, AMERICAN ACADEMY OF FAMILY PHYSICIANS

The American Academy of Family Physicians (AAFP) represents 134,600 physicians and medical students nationwide. Family physicians conduct approximately one in five of the total medical office visits in the United States per year—more than any other specialty. They delivery care in more than 90 percent of U.S. counties—in frontier, rural, suburban and urban areas. They practice in a variety of professional arrangements, including privately owned solo practices as well as large multispecialty integrated systems and public health agencies.

Family physicians provide comprehensive, evidence-based, and cost-effective primary care dedicated to improving the health of patients, families, and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.

The Medicare Access and CHIP Reauthorization Act (MACRA) created a major shift in how Medicare compensates physicians for their professional services. Congress passed MACRA to move the Medicare program away from a system that rewarded volume toward one that supports value. Family physicians continue to be among the most committed physicians to value-based care and payment—and transitioning away from fee-for-service. Our most recent annual survey of members found that:

- 41 percent practice in Patient-Centered Medical Homes (PCMHs),
- 54 percent are in value-based payment models or contracts,
- 38 percent of CPC+ participants are AAFP members, and
- Of physicians choosing to practice in an ACO, more than half are in the Medicare Shared Savings program (55 percent).

Our recommendations on what is working under MACRA—and what must be improved—are based on these collective experiences.

WHAT'S WORKING

The AAFP continues to support MACRA, most notably because it repealed the flawed sustainable growth rate formula, but also because emerging alternative payment models catalyzed by MACRA place greater emphasis on investments in family medicine and primary care. Fee-for-service payment is a barrier to many aspects of primary care transformation and the kind of primary care-based health system this country needs and deserves. The AAFP remains pleased that MACRA places a priority on the transition of physician practices from the legacy fee-for-service payment model toward alternative payment models that promote improved quality and efficiency.

Through the creation of the Advanced Alternative Payment Model pathway, MACRA created an opportunity for physicians to pursue non-fee-for-service payment. MACRA also created an opportunity for physicians to create and propose alternative payment models through the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The AAFP was one of the first organizations to successfully submit a model through the PTAC. The AAFP's Advanced Primary Care Alternative Payment Model was approved by the PTAC in December 2017, receiving

one of the strongest recommendations by the PTAC to date. The AAFP remains fully supportive of the PTAC's role in evaluating physician-focused payment models.

On April 22nd, the AAFP was pleased to join a CMS Innovation Center discussion on primary care. For more than 20 years, the AAFP and our primary care colleagues have worked to create a delivery system that encourages innovation in primary care delivery and rewards comprehensive, continuous, patient-centered care rather than single episodes of care. Throughout this time, the AAFP has provided family medicine's perspective and input. That effort is ongoing, and we continue to work with CMS and the Innovation Center to build a stronger foundation for primary care that is patient-centered and focused on value and outcomes. The announcement of the Primary Cares Initiative, which contains five new models, is a critical step toward recognizing the importance of primary care by developing payment models that value primary care. We applaud the introduction of new primary care delivery and payment models, and we look forward to working with CMS and CMMI on testing and developing these models so they are available, attractive and workable for all primary care practices, including those that are small and/or rural.

While MACRA's framework is still the right approach, operational challenges persist especially for family physicians participating in the intricate fee-for-service-based MIPS program.

WHAT'S NOT WORKING

Our recommendations focus on five main issues:

1. Correcting the undervaluation of fee-for-service payment for primary care.
2. Reducing the complexity in MIPS scoring.
3. Eliminating the MIPS APM category.
4. Extending the Advanced APM bonus.
5. Creating a culture focused on patient care.

(1) Correcting the Undervaluation of Fee-for-Service Payment for Primary Care

Even though AAFP supports movement away from fee-for-service models, the fee schedule is still a critical component of physician payment and will continue to be the foundation for future payment. Congress should direct CMS to aggressively address inequities in the Medicare fee schedule that undervalue primary care services—especially the office-based evaluation and management (E/M) codes for new and established patients. The MACRA Quality Payment Program (QPP) perpetuates the undervaluation of primary care services in the fee schedule as part of MIPS. To the extent advanced alternative payment models (AAPMs) rely on current relative values assigned to primary care services under the fee schedule, the AAPM track of QPP also perpetuates these longstanding imbalances in Medicare physician payments.

Specifically, Congress should urge CMS to increase the relative value of ambulatory E/M and other primary care services to rebalance the Medicare physician fee schedule. This is not just an AAFP perspective. It's also the perspective of Congress's own advisors, the Medicare Payment Advisory Commission (MedPAC). In its June 2018 report to the Congress, MedPAC stated:

> Ambulatory evaluation and management (E&M) services . . . are essential for a high-quality, coordinated health care delivery system. These visits enable clinicians to diagnose and manage patients' chronic conditions, treat acute illnesses, develop care plans, coordinate care across providers and settings, and discuss patients' preferences. E&M services are critical for both primary care and specialty care. The Commission is concerned that these services are underpriced in the fee schedule for physicians and other health professionals ("the fee schedule") relative to other services, such as procedures. This mispricing may lead to problems with beneficiary access to these services and, over the longer term, may even influence the pipeline of physicians in specialties that tend to provide a large share of E&M services.[1]

We share MedPAC's concern, and like MedPAC, we believe CMS should use a budget-neutral approach that would increase payment rates for ambulatory E/M

[1] Medicare Payment Advisory Commission. *June 2018 Report to the Congress: Medicare and the Health Care Delivery System.* P. 65. *http://www.medpac.gov/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf?sfvrsn=0.* Accessed February 6, 2019.

services while reducing payment rates for other services (*e.g.,* procedures, imaging, and tests). Primary care services must be held harmless from any necessary budget-neutrality adjustments resulting from an increase in the relative value of primary care services. Otherwise, the positive impact of those increases will be diluted. Thus such budget neutrality should not occur by adjusting the conversion factor but rather reducing the payment rates for non-E/M services.

(2) Reducing MIPS Scoring Complexity

The implementation of MIPS has created a burdensome and extremely complex program. Primary care practices' main priority is to remain singularly focused on delivering high-quality patient care. However, understanding the requirements and scoring for each performance category and reporting data to CMS is a complex task and detracts from primary care practices' ability to focus on patients. Unfortunately, CMS continues to struggle to provide timely and clinically actionable data because the MIPS cost category measures are flawed and hold primary care physicians more accountable for total cost of care than other sub-specialties. We urge Congress to extend CMS's authority to weigh the MIPS cost category below 30 percent to allow time to overhaul existing measures.

One of the more concerning portions of MIPS is the Promoting Interoperability (PI) category. CMS is hamstrung in PI since the agency is bound to Meaningful Use requirements by legislation, including both the American Recovery and Reinvestment Act and the Affordable Care Act. The AAFP calls on Congress to repeal Meaningful Use requirements and allow HHS to remove these requirements from the PI category. We are pleased that HHS is pursuing interoperability and stopping information blocking through rulemaking and are preparing extensive comments, due in early June.

While the AAFP appreciates the efforts to simplify the PI category, we remain extremely concerned and adamantly opposed to the "all or nothing" nature of the category. CMS believes the category is not "all or nothing," as an eligible clinician can submit a numerator as low as one. However, failure to report one measure results in a category score of zero. For all intents and purposes, this is an "all or nothing" structure.

CMS should eliminate health IT utilization measures and remove any required measures and provide eligible clinicians the flexibility to select measures relevant to their practice. All measures within the promoting interoperability category should be attestation-based.

Congress and CMS should work together to improve the implementation of the PI category by removing legislative barriers that restrain and complicate the category. Congress should encourage CMS to simplify the scoring, remove health IT utilization measures and the "all or nothing" requirement, and hold Health IT vendors accountable for interoperability before measuring physicians on EHR use.

The AAFP is supportive of the industry's move to 2015 edition CEHRT. Yet, we have concerns with it being mandated for eligible clinicians (ECs). We must also realize that adopting a 2015 edition CEHRT does not mean that a practice or hospital will be interoperable. Mandates are more beneficial to health information technology (IT) developers than to ECs. Mandates relieve market pressures to lower the cost of upgrades and increase the value of upgraded versions. The cost of EHRs continues to rise, whereas IT cost in every other industry has decreased. We strongly encourage CMS to not mandate 2015 edition CEHRT, but rather incentivize its adoption through scoring, which benefits 2015 edition CEHRT users.

In a letter the AAFP sent HHS early this year, we discussed how Health IT and EHR vendors should be more fully regulated to address mal-aligned and self-serving behaviors by these vendors. An HHS draft report laid out a set of strategies and recommendations and the AAFP was largely supportive of them. However, the AAFP strongly urges HHS to convert the "could," "should," and "encourage" language in the report into *required* actions. Compliance with these mandates by vendors will significantly decrease the administrative burdens of physicians. It is time for them to be mandates and not suggestions.

Congress should guide CMS to reduce the complexity and administrative burden of MIPS. CMS could accomplish this by providing cross-category credit for measures and activities that span multiple performance categories. We believe an updated architecture where reporting once and receiving credit in multiple categories could alleviate significant burden from practices and allow them to focus their efforts on better patient care.

(3) Eliminating the MIPS APM Category

The AAFP remains quite concerned with the MIPS APM option created by CMS but not referenced in MACRA's statutory language. The AAFP is concerned eligible clinicians may intentionally remain in MIPS APMs, given the scoring advantage they have been given, instead of progressing toward advanced APMs, which was the congressional intent behind MACRA.

By remaining in MIPS, MIPS APMs will skew the MIPS performance threshold. This is already apparent in the 2017 performance period, where the performance threshold was three and the exceptional performance threshold was 70. MIPS APMs tend to be larger practices that are part of an accountable care organization (ACO), which has the resources and technology to better support their MIPS participation. In the 2017 Quality Payment Program (QPP) Reporting Experience report published by CMS, MIPS APMs had a mean final score of 87.64 and median final score of 91.76. The MIPS APM final scores are higher than the national mean and median final scores which were 74.01 and 88.97. Even more disconcerting is the difference between MIPS APM scores and scores of small and rural practices. The mean and median final scores for small practices were 43.46 and 37.67, respectively. This is a significant discrepancy that favors MIPS APMs and compromises the integrity of the program.

(4) Extending the Advanced APM Bonus

Given the limited availability of AAPMs to date, we strongly urge Congress to extend the 5 percent Advanced APM bonus for three to 5 years beyond the current statutory restriction and include language giving the Secretary of HHS discretion to extend the bonus further.

(5) Creating a culture focused on patient care

Feedback we have received is that most family physicians, especially those in independent practices, believe that the MIPS program has a net-negative impact on their practices. While comfort with the existing fee-for-service system may play a role, the feedback we have received from family physicians, based on analysis of their practice trends, suggest that the MIPS program requirements place economic strains on their practices.

The AAFP strongly supports streamlining MIPS documentation requirements and reducing administrative burden in all health care programs—both public and private. One of the most onerous administrative burdens is prior authorization, which tops the list of physician complaints on administrative burden. This uncompensated work for physicians and staff translates into increased overhead costs for practices, disrupts workflows, and results in inefficiencies and reduction in time spent with patients. According to AMA data, interactions with insurers cost $82,975 annually per physician. Exacerbating this is most family physicians in private practice have contractual relationships with seven or more health insurance plans, including Medicare and Medicaid. In coalition with 16 other medical organizations, the AAFP has called for the reform of prior authorization and utilization management requirements that impede patient care in *Prior Authorization and Utilization Management Reform Principles.* In addition, the AAFP has published, *Principles for Administrative Simplification,* calling for an immediate reduction in the regulatory and administrative requirements family physicians and practices must comply with daily.

Quality measure reporting is another source of administrative burden for physicians and their practices. According to a study discussed in *Health Affairs,* physician practices spend, on average, 785 hours per physician and more than $15.4 billion annually to report quality measures. Quality reporting takes considerable time away from patient care while causing a considerable financial strain on practices, particularly those that are small and/or rural.

The AAFP strongly supports the CMS Patients Over Paperwork initiative but believes more must be done to improve patient care within the MIPS program by reducing administrative burdens. So that family physicians can devote more time to patient care, we urge Congress to influence action by all payers to reduce the administrative complexity so that physicians can more fully focus on patient care.

ADDITIONAL RECOMMENDATIONS

The AAFP makes the following recommendations to improve Medicare payment systems:

1. Congress should extend the 0.5-percent baseline conversion factor update until 2026. Doing so would help mitigate budget-neutrality cuts required by

separate laws such as the Protecting Access to Medicare Act (PAMA) and help adjust for inflation. This rate of increase does not match increase in cost or inflation, but it does provide a minimum level of economic growth.

2. Congress should encourage CMS to continue to focus on outcomes and patient-reported outcome measures that are more impactful for a practice and for patients.
3. The AAFP asks Congress to reimagine how the exceptional performance positive payment adjustments are applied to reward practices that achieve significant year-over-year improvement versus rewarding those practices at the upper levels of annual performance. In 2019, practices that achieve a final score of 75 points are eligible for up to an additional 10 percent positive payment adjustment. While we applaud these high-performing practices, it is our belief that additional positive payment adjustments would be better used if they were focused on rewarding the hard work of practices that achieve year-over-year improvements.

CONCLUSION

Once again, thank you for the opportunity to discuss with this committee the impact of MACRA on family physicians and its potential to build a patient-focused health care delivery system built upon a well-resourced foundation of primary care.

QUESTIONS SUBMITTED FOR THE RECORD TO JOHN S. CULLEN, M.D., FAAFP

QUESTIONS SUBMITTED BY HON. ROB PORTMAN

Question. I introduced the Medicare Care Coordination Improvement Act with Senator Bennet in an effort to reduce some of the barriers that providers face when they participate in Alternative Payment Models. However, one particular section of my bill focuses on providing temporary waivers to practices that are interested in testing their own APMs. HHS has been slow to take up new APM concepts, and thus: what can we do to incentivize the establishment of new APMs? Has the PTAC offered a viable way to propose and test new APMs? If not, what actions could be taken to encourage the adoption of PTAC models?

Answer. *Establishing New and Increasing Participation in APMs:* The AAFP is committed to transforming the Medicare program into one that prioritizes the delivery of high-quality, patient-centered, and efficient care. As we have previously stated, and literature supports, achieving meaningful transformation of our health-care system starts with creating a system foundational in primary care—and increased investment in primary care to sustain the transformation. Unfortunately, a recently released RAND study estimated that only 2–5 percent of Medicare spending is on primary care. This is despite the growing evidence on the positive impacts of primary care on quality, lower rates of mortality and overall system spending.

As a result, we recommend that Congress require CMS to establish APMs that significantly increase investments in primary care—andexpand existing APMs, such as CPC+ to encourage greater participation among primary care practices. AAFP would welcome the opportunity to work with Senators and the committee to develop proposals to accomplish these objectives.

Reevaluation of Primary Care Payments in Medicare: The AAFP also recommends that the committee support revaluation of ambulatory E&M services, which is critical to move physicians into value-based, Advanced Alternative Payment Models (AAPMs). As MedPAC observed in its June 2018 report, all Advanced APM models use fee-for-service payment rates as either the basis of payment or the reference price for setting the global or bundled payment amount. If the actuarial basis for E&M payment alternatives is the relative values currently assigned to E&M services under fee-for-service, then the foundation of the corresponding Advanced APM is fundamentally flawed and will undermine efforts to create viable APMs for primary care to participate in.

Like MedPAC, we believe CMS should use a budget-neutral approach that would increase payment rates for ambulatory E/M services while reducing payment rates for other services (*e.g.,* procedures, imaging, and tests). Thus, the committee should support the revaluation of ambulatory E&M codes to ensure CMS succeeds in moving physicians into value-based, APMs.

Another way Congress could promote the adoption of APMs is to address low Medicaid physician payment rates which have historically created a barrier to healthcare access for Medicaid enrollees. AAFP policy [1] supports Medicaid payment for primary care services at least equal to Medicare's payment rate for those services when provided by a primary care physician. Accordingly, we urge Congress to resume Federal primary-care payment policy previously found in Medicaid—SSA 1902(a)(13)(C) and provide Federal funding to ensure a floor of Medicare payment rates for primary care services in Medicaid.

Physician-Focused Payment Model Technical Advisory Committee (PTAC): Through the creation of the Advanced APM pathway, MACRA created an opportunity for physicians to pursue non-fee-for-service payment. MACRA also created an opportunity for physicians to create and propose alternative payment models through the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The AAFP was one of the first organizations to successfully submit a model through the PTAC. The AAFP's Advanced Primary Care Alternative Payment Model was approved by the PTAC in December 2017, receiving one of the strongest recommendations by the PTAC to date. Following approval of the APC–APM, the AAFP worked with CMS and the Innovation Center to inform the design of the Primary Care First (PCF) model—but unfortunately as currently designed it does not in our view represent an increased investment in primary care as proposed in the AAFP's APC–APM PTAC approved APM model. We continue to advocate for improvements to the model to better align with the AAFP's APC–APM proposal. The AAFP remains fully supportive of the PTAC's role in evaluating physician-focused payment models.

Question. Per data from CMS, about half of all Medicare providers are participating in MIPS, with the majority of these non-participating providers being exempt via the low-volume threshold. While we don't want to place additional burdens on small and rural providers, we should be identifying ways to engage with these practices to help them transition towards value-based outcomes.

What actions should be taken to engage with these providers?

Answer. *Burden of Reporting for Small Practices:* The current MIPS reporting requirements necessitate an expanded human and technological infrastructure that many practices cannot afford, including most small rural practices. In the AAFP's 2017 Value-based Payment Study, 70 percent of respondents indicated lack of staff time as a barrier to implementing value-based care, while 41 percent indicated the financial investment required for health information technology (HIT) is a barrier. Among practice owners, 74 percent cite lack of staff time and 52 percent cite financial investment as barriers to implementing value-based care. Further, CMS continues to change program requirements, which makes compliance a moving target. Rural practices do not have the resources to dedicate staff solely to MIPS reporting as their staff is primarily involved in patient care. To reduce reporting burden for all MIPS clinicians, Congress should allow CMS to provide scoring flexibility through multi-category credit. The AAFP's written testimony provides additional details on how this could be implemented.

There should be a single set of performance measures across all payers that are universal, meet the highest standards of validity, reliability, feasibility, importance, and risk adjustment. The measures should focus on outcomes that matter most to patients and that have the greatest overall impact on better health of the population, better health care, and lower costs.

Measures of performance should be derived from data that are extracted from multiple data sources rather than self-reported by physicians and their teams. Self-reported data are seldom validated for accuracy, reliability, missing data, coding variation, and application of measure specifications. Elimination of self-reporting will end current financial penalties for non-reporting that disproportionately impact small practices. Data extraction will reduce administrative burden and resolve comparability problems in performance data submitted through various mechanisms. Health IT advancements are needed, but physicians cannot be expected to continue bearing the burden of data collection and reporting while awaiting technological solutions.

Process measures that rely on self-measurement are best used for internal quality improvement efforts to drive changes and improvements to achieve higher level outcomes.

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[1] *https://www.aafp.org/about/policies/all/medicaid-principles.html.*

Performance measures should be applied at a system level, as on their own individual health-care professional have limited ability to drive outcomes and are constrained by the environment and systems in which they practice. Performance measures can identify gaps in services and outcomes at the entity, community, and population levels, and they can be used to direct allocation of public and private resources to address unmet needs. Such measures should lead to investment of resources to improve equity, access, and socioeconomic factors that impact health and health care.

One of the more concerning portions of MIPS is the promoting interoperability (PI) category. CMS is hamstrung in PI since the agency is bound to Meaningful Use requirements by legislation, including both the American Recovery and Reinvestment Act and the Affordable Care Act. The AAFP calls on Congress to repeal Meaningful Use requirements and allow HHS to remove these requirements from the PI category.

Congress and CMS should work together to improve the implementation of the PI category by removing legislative barriers that restrain and complicate the category. Congress should encourage CMS to simplify the scoring, remove health IT utilization measures and the "all or nothing" requirement, and hold health IT vendors accountable for interoperability before measuring physicians on EHR use.

Electronic Health Records (EHRs) Continue to Pose Significant Challenges for Small and Rural Practices:[2] With fewer resources available, some rural practices use less expensive EHRs that have limited capabilities, which can make interoperability significantly more difficult. Additionally, EHRs often lack adequate technical support or may charge for providing basic user support. CMS's mandate to implement 2015 Edition certified EHR technology requires additional financial investments and staff support further inflate the barriers to successful value-based payment participation for rural practices. The AAFP welcomes the opportunity to partner with the committee as it considers ways to boost clinically meaningful HIT use among small practices.

Allow CMS to Set MIPS Performance Thresholds Based on Practice Size: Rural practices, particularly small rural practices, have unique challenges as compared to large practices in urban and suburban areas. Small, rural practices typically have fewer staff and limited resources to manage the Merit-based Incentive Payment System (MIPS) reporting requirements that otherwise burden all participants. The challenge to participate is demonstrated by the mean and median 2017 MIPS final scores for rural practices, which were 63 and 75 respectively. In contrast, MIPS Alternative Payment Model (APM) participants, which tend to be large practices, had a mean score of 88 and a median score of 92. To address this scoring and ultimate payment adjustment disparity, Congress should provide CMS additional flexibility to establish multiple performance thresholds for practices dependent on size. Separate performance thresholds would allow CMS to set thresholds that better reflect a practice's ability to meaningfully participate in MIPS—potentially narrowing the gap between small and large practices and facilitating a move to practice accountability. An inflated performance threshold will disproportionately reward large practices with more resources while effectively punishing small and rural practices that have fewer resources. Without an attainable performance threshold for small and rural practices, the program's goal to move practices to performance accountability is diminished.

Accommodations for Higher Rural Practice Costs: Rural areas also tend to have fewer sub-specialists, resulting in rural patients receiving nearly all their health care from their primary care physician. When sub-specialists are available, there is a smaller network from which to choose. As a result, rural primary care practices could have higher costs as compared to urban and suburban practices with a larger referral network. Additionally, ensuring patients receive timely and appropriate preventive care is difficult for rural practices, as patients can be unwilling to travel long distances. Higher costs negatively impact rural practices' MIPS performance relative to their urban and suburban counterparts and makes them potentially less attractive to entities in Advanced Alternative Payment Models. Congress should extend CMS's authority to reweight the MIPS cost category until such time when valid and reliable cost measures are available for all eligible clinicians. The committee should consider ways to ensure the MIPS cost category fairly captures and represents the costs of care in rural areas where primary care physicians often provide a broad range of services to their communities.

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[2] *https://www.gao.gov/assets/700/692179.pdf.*

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. The Independence at Home demonstration, which was expanded and extended last year through the CHRONIC Care Act, enables care teams to deliver high-quality primary care to Medicare beneficiaries in the comfort of their own homes. In its third performance year, according to the Centers for Medicare and Medicaid Services (CMS), Independence at Home saved $16.3 million for the Medicare program.[3] A recent evaluation also found that Independence at Home has resulted in fewer emergency department visits leading to hospitalization, a lower proportion of beneficiaries with at least one unplanned hospital readmission during the year, and a reduced number of preventable hospital admissions.[4] As I mentioned at the hearing, I am committed to building on the success of the Independence at Home demonstration. As discussed at the hearing, I understand that the new Primary Care First model recently announced by CMMI (the Center for Medicare and Medicaid Innovation at CMS) may provide an avenue to expand access to home-based primary care for more Medicare beneficiaries.

Based on your members' experience in Independence at Home and other Alternative Payment Models, what key components will be necessary in order for the Primary Care First model to expand access to home-based primary care?

Answer. Home Based Primary Care (HBPC) provides value for chronically ill, medically complex, homebound patients in terms of quality and overall cost reduction. Payment reform and new models of care (including Primary Care First and Direct Contracting) are supportive of HBPC. Despite this, attempting to do HBPC as a solo/independent provider is challenging due to factors such as call rotation, establishing/training a care team, community outreach/referral, uninsured patients, and reduced patient volume. HBPC depends on ACO-type goals that allow investment in programs that lead to overall reduction in health system costs.

To expand access to home-based primary care, Medicare payment must be based on continuing, comprehensive care and should encourage treatment on an ambulatory basis rather than in a costly institutional setting. The AAFP advocates for efforts to align payment policies for physicians in independent practice with those owned by hospitals. The AAFP encourages consideration of site-of-service payment parity polices from a broad perspective. Namely, CMS should not pay more for the same services in the inpatient, outpatient, or ambulatory surgical center setting than in the physician office setting. The AAFP calls for incentives for services to be performed in the most cost-effective location, such as a physician's office. The AAFP considers the artificial distinction between "inpatient," "outpatient," and other sites of service as a product of the equally artificial distinction between Medicare's Part A and Part B. The AAFP calls for policies that progress beyond this silo mentality and instead pay for health-care services in a more consistent and equitable manner.

The AAFP also encourages alignment between alternative payment models and the benefit enhancements and payment waivers offered. Waivers that would facilitate cost effective home-based primary care include the Telehealth Expansion Waiver, Post-Discharge Home Visits Rule Waiver, and Care Management Home Visits Rule Waiver. We also recommend exploring other waivers that reduce barriers to home-based primary care, like extending the ability to certify a patient's eligibility for home health services to other members of the care team and allowing home health services to be offered to patients who do not meet the definition of "homebound" but would otherwise benefit from receiving some or all of their health care at home.

Question. What other specific policies would you recommend Congress or CMS consider to expand access to home-based primary care for more Medicare beneficiaries?

Answer. As stated above, Medicare payment must be based on continuing, comprehensive care and should encourage treatment on an ambulatory basis rather than in a costly institutional setting.

Question. As I mentioned during the hearing, I often hear from seniors in Oregon that they don't feel like anyone is in charge of managing their health care and helping them navigate the health-care system. I am proud of the bipartisan work that this committee did on the CHRONIC Care Act last Congress to update the Medicare

[3] *https://innovation.cms.gov/Files/fact-sheet/iah-yr3-fs.pdf.*
[4] *https://innovation.cms.gov/Files/reports/iah-rtc.pdf.*

guarantee. In my view, the next step should be making sure that all Medicare beneficiaries with chronic illnesses have someone running point on their health care—in other words, a chronic care point guard—regardless of whether they get their care through Medicare Advantage (MA), an Accountable Care Organization (ACO) or other Alternative Payment Model, or traditional fee-for-service Medicare.

For beneficiaries in traditional, fee-for-service Medicare, what can be done to improve care coordination and make sure their physicians and other health-care professionals are all talking to each other and working together to provide the best possible care to those beneficiaries? What specific policies would you recommend this committee pursue toward that end?

Answer. *Data Sharing/EHRs:* Family physicians, above all else, seek to protect the well-being and health of their patients. Increasingly in today's health-care landscape, primary care physicians are accountable for safe and effective coordination of care and care management, as an integral component of routine business practices. The primary care physician should have access to information contained in a clearinghouse and be given data (treatment and diagnostic codes, dates, medications, provider name/contact information) on all procedures, treatments, and diagnoses billed by all other entities to enhance the ability of primary care to safely and effectively coordinate care and manage costs. This data should be in a standard form that is importable into the EHR without special effort by the primary care physician team.

Patients value the ability to easily access all their health data in one place. Access to complete data improves patient ability to better engage in care which leads to better outcomes. Patients can be extremely effective partners in care coordination when they have easy access to all their data and are able to share it with all health-care professionals.

Interoperability is a critical issue. Since Meaningful Use an appropriate growth in the exchange of health records occurred. Unfortunately, these records are merely in standard formats that allow data to be transmitted between EHR systems and *not* yet in forms that allow automated importing into the patient's record in the receiving EHR or for authorized applications to extract key patient data. The consequences create a tremendous amount of burden placed on the physician to scour information for buried key clinical information and then "re-key" that data into the patient's EHR. Without what is called semantic interoperability (*i.e.,* shared meaning), this will continue to be a burden to physicians and create patient safety risk. While there are pockets of such importable data, there is not widespread or expansive in the types of clinical data covered. The AAFP believes that HHS has the authority needed to address the current issues through MACRA and the 21st Century Cures Act. We ask Congress to provide continued oversight of HHS's implementation of these laws.

Payments for Care Management: Care coordination is also possible when practices have resources to support non-face-to-face care management. Primary care practices should receive care management fees or population-based payments that support consultations across providers. This includes reimbursement for non-face-to-face care management. The AAFP suggests Congress and CMS consider a care management fee or population-based payment for non-face-to-face care management that can support consultations and care coordination.

Question. Please describe the specific steps that Congress and/or CMS could take to ensure all Medicare beneficiaries with chronic illnesses, including those in traditional fee-for-service Medicare, have a chronic care point guard.

Answer. *Access to Primary Care Physicians:* All Medicare beneficiaries should be attributed to one primary care physician that agrees to be responsible for overall care. Waiving co-pays for seeing their primary care providers is essential to discourage patients from going directly to sub-specialist without seeking primary care first. Notification to the PCP of care provided by all other entities should be mandatory. Payers should be held accountable for making certain all their beneficiaries have a primary care physician that has agreed to be responsible for overall care.

Congress and CMS should only allow physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis to bill services such as the Chronic Care Management (CCM) code. A primary care physician is a specialist in family medicine, internal medicine, or pediatrics who provides definitive care to the undifferentiated patient at the point of first con-

tact and takes continuing responsibility for providing the comprehensive care to the patient. Such a physician must be specifically trained to provide comprehensive primary care services through residency or fellowship training in acute and chronic care settings. Physicians who are not trained in the primary care specialties of family medicine, general internal medicine, or general pediatrics, at times, may provide some primary care "services" that are similar to those usually delivered by primary care physicians—but this does not constitute primary care. These physicians may focus on specific patient care needs related to prevention, health maintenance, acute care, chronic care, or rehabilitation. These physicians, however, do not offer these services within the context of comprehensive, first contact, and continuing care.

Further, we urge Congress to eliminate the applicability of deductible and coinsurance requirements for the CCM codes. Eliminating CCM cost-sharing requirements would facilitate greater utilization of these codes and increase coordination of care for those beneficiaries with the greatest health-care needs.

Access to Patient-Centered Medical Homes: In 2018, the AAFP Board of Directors approved the "Health Care for All" policy, which includes a number of guiding principles and considerations for health reform. One of these guiding principles is the establishment of a primary care-based health system, which include ensuring access to a primary care physician and a medical home for all Americans. In an annual[5] review of evidence of the PCMH's impact on cost and quality, the Patient-Centered Primary Care Collaborative identifies several PCMH programs that have reduced costs and improved quality. Medical homes are associated with:

- Better coordinated, more comprehensive, and personalized care.
- Improved access to medical care and services.
- Improved health outcomes, especially for patients who have chronic conditions.

Payment Adjustments for the Social Determinants of Health: The AAFP policy on "Advancing Health Equity: Principles to Address the Social Determinants of Health in Alternative Payment Models" provides suggestions for how alternative payment models should account for SDoH in their payment methodologies and enable physician practices to overcome these barriers. We encourage policymakers to review this policy to create similar structures and incentives to motivate and enable practices to address social determinants of health.

Question. Eligible clinicians who receive a certain percentage of their payments or see a certain percentage of their patients through Advanced APMs are excluded from MIPS and qualify for the 5 percent incentive payment for payment years 2019 through 2024. Starting this year (performance year 2019), eligible clinicians may also become qualifying APM participants (and thus qualify for incentive payments in 2021) based in part on participation in Other Payer Advanced APMs developed by non-Medicare payers, such as private insurers, including Medicare Advantage plans, or State Medicaid programs.

Recognizing that this is the first year in which the All-Payer Combination Option is available, how many of your members do you anticipate will take advantage of the All-Payer Combination Option this year?

Answer. The AAFP is supportive of the All-Payer Combination Option but has not heard substantial feedback from members on it.

Question. What, if any, challenges have your members faced when attempting to take advantage of the All-Payer Combination Option?

Answer. The AAFP believes the onus of submitting relevant information on payer arrangements should fall to the payers. This is currently voluntary for payers. While the AAFP believes payers should be responsible for submitting information to CMS, we have heard from payers that the process is complicated and burdensome.

We encourage Congress to reduce the qualifying participant thresholds since there currently are not many APMs and strongly urge Congress to extend the 5-percent Advanced APM bonus for 3 to 5 years beyond the current statutory restriction and include language giving the Secretary of HHS discretion to extend the bonus further.

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[5] *https://www.pcpcc.org/sites/default/files/resources/The%20Patient-Centered%20Medical%20Home%27s%20Impact%20on%20Cost%20and%20Quality%2C%20Annual%20Review%20of%20Evidence%2C%202014-2015.pdf.*

We anticipate challenges in reporting performance data because measures are not aligned among payers. Please see our comments above regarding the need for a single set of performance measures that are universal, meet the highest standards of validity, reliability, feasibility, importance, and risk-adjustment. The measures should focus on outcomes that matter most to patients and that have the greatest overall impact on better health of the population, better health care, and lower costs. Measures of performance should be derived from data that are extracted from multiple data sources rather than self-reported by physicians and their teams.

Question. In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress provided a total of $100 million over 5 years for technical assistance to MIPS-eligible clinicians in practices with 15 or fewer clinicians, focusing on rural and health professional shortage areas.

To what extent have your members utilized the services of the Small, Underserved and Rural Support Initiative, which CMS launched using the MACRA funding to provide free, customized technical assistance to clinicians in small practices?

Answer. We promote to our members CMS education services as well as AAFP education opportunities. The AAFP encourages Congress to provide additional funds for technical assistance and use the $500M bonus pool to support small practice transformation.

Question. What types of technical assistance and support have been most helpful to physicians and practices (*e.g.,* understanding program requirements, selecting appropriate measures, forming virtual groups)?

Answer. Congress provided technical assistance funds for CMS to support practices in MIPS. CMS created the Small, Rural, and Underserved Support (SURS). While these organizations have been helpful, they are unable to provide the in-depth and individualized support many small and rural practices need. The services provided[6] vary by each organization and may not be available to all practices. Additionally, the organizations can provide technical support, but they do not provide any financial or permanent human resources for practices. Stakeholders interviewed for a recent RAND report[7] felt the QPP support is able to provide high-level support, but much of the work cannot be done by outside contractors or office managers. Stakeholders also reported that the support providers sometimes lacked knowledge in certain areas or were unable to get answers from CMS to specific questions. Specifically, funds are needed to pay for IT support specific to individual users. Technical assistance providers lack specific IT knowledge and funds to implement real solutions.

Second, the AAFP would recommend the exceptional performance bonus payments be reimagined to reward practices that achieve significant year-over-year improvement versus rewarding those practices at the upper levels of annual performance. While we applaud these high-performing practices, it is our belief that additional positive payment adjustments would be better used if they were focused on rewarding the hard work of practices that achieve year-over-year improvements.

The AAFP has not received any feedback from members regarding virtual groups and the uptake has been low. In fact, for the 2019 performance year, CMS estimated that only 80 TINs would form 16 virtual groups. While the intentions behind virtual groups were good, the implementation and policies have fallen short. For example, those who fell below the low-volume threshold but wanted to participate in a virtual group could voluntarily report but would not receive a payment adjustment. This policy made virtual groups unattractive to those practices that virtual groups were designed to help. CMS now offers an opt-in pathway for practices that are otherwise excluded to fully participate in MIPS. However, this does not alleviate the challenges practices face in trying to identify other high performing practices with which to form a virtual group. Nor does the opt-in pathway remove the administrative and infrastructure barriers presented by virtual groups. In addition, CMS does not aggregate data for virtual groups. The burden of collecting and reporting data across multiple practices (and multiple EHRs) falls solely to the virtual group. Since virtual group practices are, by definition, small, it is unlikely they have the time or resources to take on such an arduous task. These concerns are echoed in the RAND

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[6] *https://www.gao.gov/assets/690/681541.pdf.*

[7] *https://www.rand.org/content/dam/rand/pubs/research_reports/RR2800/RR2882/RAND_RR2882.pdf.*

research report "Perspectives of Physicians in Small Rural Practices on the Medicare Quality Payment Program."[8]

We stand ready to work with Congress and CMS to make virtual group options more robust for small and rural practices.

QUESTIONS SUBMITTED BY HON. DEBBIE STABENOW

Question. Last time this committee discussed MACRA in 2016, I asked Andy Slavitt, then Acting Administrator of CMS, about the agency's plans to make it easier for rural physician practices to participate in APMs and MIPS. For example, some rural communities lack the required technology for electronic health records to participate. As someone who has experience with rural communities in your home State of Alaska, what changes have you noticed in rural communities and what could be improved to better accommodate rural physicians?

Answer. As committee members have noted, it is also difficult for rural practices to participate in Alternative Payment Models (APMs). The infrastructure challenges are just as significant in APMs as they are in MIPS, and there are simply a limited number of Advanced APMs (AAPM) available. Limited financial[9] resources and reserves make it difficult for rural practices to assume financial risk. A key component to successful APM and AAPM participation includes the implementation the five key functions of a medical home.[10] The up-front investments needed[11] for participation in value-based models can be significant, compounding the difficulties for participating. The AAFP welcomes the opportunity to partner with the committee to ensure that the MIPS program prepares practices for APM participation, and that CMS and the Innovation Center are creating APMs for rural and small practice participation.

The AAFP strongly encourages Congress to provide additional funds for technical assistance and use the $500M bonus pool to support small practice transformation.

Question. I am very proud of the work the bipartisan accomplishments to address Alzheimer's, including the implementation of my HOPE for Alzheimer's Act which required Medicare to pay for new individual care plans to support Alzheimer's patients and their families. Many of my colleagues are also cosponsors of my Improving HOPE for Alzheimer's Act, which will ensure beneficiaries and physicians know that they are able to access, and bill for, care planning under Medicare. In our last hearing on MACRA implementation, my colleagues raised the question of how we should look at quality measures in MIPS when it comes to physicians having these conversations with beneficiaries and their families and reflecting their priorities. Some have mentioned altering MIPS to make the quality measures more clinically meaningful. In what ways do you think the system would need to change to better incorporate long-term care planning and encourage physicians to have these conversations with patients?

Answer. In general, the AAFP is discouraging the creation of numerous additional performance measures that focus on processes. Giving in to the temptation to measure everything that can be measured drives up cost, adds to administrative burden, contributes to professional dissatisfaction and burnout, encourages siloed care, undermines professional autonomy, and diverts resources away from the most important factors influencing health and health care, such as SDoH. Extensive experience with performance measures in various systems (*e.g.,* the VA system, the United Kingdom: Quality and Outcomes Framework) has shown excessive measurement can cause unexpected harms while failing to have an enduring positive impact on health outcomes of interest.

In addition, quality measures under MIPS are voluntary—professionals choose measures they wish to report, so measures aren't consistently selected or applied to all beneficiaries—this leads to a minimal impact on outcomes.

A better solution may be to incorporate a more structured approach to screening and paying an additional fee for screening and follow-up.

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[8] *https://www.rand.org/content/dam/rand/pubs/research_reports/RR2800/RR2882/RAND_RR2882.pdf.*
[9] *https://www.gao.gov/assets/690/681541.pdf.*
[10] *https://www.aafp.org/practice-management/transformation/pcmh.html.*
[11] *https://www.gao.gov/assets/690/681541.pdf.*

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

THE PATIENT VOICE IN MACRA

Question. In your testimony, you mention the importance of patient-reported outcomes. I agree that we should be measuring whether or not we are paying for care that is in line with the patient's goals. During the hearing I asked you how many of the 424 MIPS measures consider the patient voice and their priorities.

Can you provide that number for me?

Answer. Seventeen MIPS measures are classified as patient-reported outcome measures with 3 additional outcome measures that are not classified as such but are in fact patient-reported.

Question. What more can your physician organization do to ensure patient needs and priorities are kept at the center of health-care delivery?

Answer. Physicians could increase their use of patient-reported outcome measures (PROMs), but assessment alone is not enough to improve outcomes. Adequate community resources and social support systems are needed to address what the PROM reveals. Physicians alone cannot meet all patient needs but must rely on referral to community resources designed to address SDoH and non-clinical needs.

It is important to clarify that measuring an outcome may not translate into good or bad clinician performance. A major challenge of using PROMs for performance measurement is demonstrating that the outcome is influenced by the care provided, and not attributable to other factors, such as social determinants of health. Without such evidence, the performance measure would not be considered a valid indicator of clinical performance. Like all performance measures, patient reported outcome performance measures must also be monitored to ensure there are no unintended consequences, such as potential for adverse patient selection. In addition, data must be feasible to collect, but data standards and integration into the EHR are only beginning to evolve.

Challenges with using patient-reported outcomes in performance measurement are substantial. The Massachusetts Medical Society concluded that PROMs are a valid tool for internal quality improvement, clinical care, and patient engagement, but are still in their infancy and "should not be used to compare providers or outcomes for payment." The AAFP has taken the position that that many measures appropriate for use as quality measures for internal improvement purposes may not be appropriate as performance measures.

Question. What more can and should CMS and Congress do to ensure patient needs and priorities are kept at the center of health-care delivery?

Answer. CMS must ensure that performance measure are limited to factors that have the greatest impact on health, health care, and costs, and are within reasonable control of the entities or professionals to which payment adjustments apply to avoid unintended consequences of measurement.

Primary care services should be exempt from cost-sharing requirements such as deductibles and co-payments. For instance, the establishment of a standard primary care benefit[12] would guarantee connectivity to the health-care system for individuals with high-deductible health plans and serve as a guardrail against disease progression that leads to more costly care. The committee should strongly support the Primary Care Patient Protection Act of 2018 (HR 5858)—a bipartisan bill to make it more affordable for patients with HDHPs to access primary care.

Ensuring connectivity to a health-care delivery system through continuous, comprehensive, primary care is not only solid health policy; it also is sound economic policy for individuals and employers. A recent study[13] conducted by the University of Portland found that every $1 invested in advanced primary care practices resulted in $13 in savings in other health-care services, including specialty, emergency room, and inpatient care.

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[12] *https://www.aafp.org/dam/AAFP/documents/events/fmas/BKG-StandardPrimaryCareBenefitHighDeductiblePlans.pdf.*

[13] *https://www.oregon.gov/oha/hpa/dsi-pcpch/Pages/index.aspx.*

When patients delay primary or preventive medical care, they often end up in an emergency room. According to a poll[14] conducted by the American College of Emergency Physicians, about 80 percent of emergency physicians said they are treating insured patients who have sacrificed or delayed medical care due to unaffordable out-of-pocket costs, coinsurance, or high deductibles. A 2013 study[15] found that high-deductible health plans (HDHPs) led to decreased adherence to pharmaceutical treatments for patients with chronic conditions. The decrease in pharmaceutical adherence contributes to poor control of chronic conditions, which leads to the probability of more intensive and expensive health-care treatments at some future date.

These findings further support the need to ensure individuals have connectivity with the health-care system through a constant relationship with a primary care physician. The cost of not ensuring continuous primary care is substantial. For example, the average cost of a visit to a primary care physician is $160.[16] By comparison, the median charge for outpatient conditions in the emergency room is $1,233[17] and the average hospital stay is $10,000.[18] Based on these indicators, patients could see their primary care physician 7.7 times for the cost of a single visit to the emergency room and 62.5 times for a single hospital admission. Furthermore, it is estimated that more than $18 billion[19] could be saved annually if those patients whose medical problems are considered "avoidable" or "non-urgent" were to take advantage of primary or preventive health care and not rely on emergency rooms for their medical needs. Primary care physicians are in the best position to serve as a patient's "chronic care point guard" and provide the quality and longitudinal care that can improve patient outcomes and reduce downstream costs.

It is well known that the United States, as compared to other Organisation for Economic Co-operation and Development (OECD) countries, spends a greater percentage of the gross domestic product on health care, yet has a significantly lower life expectancy. Many researchers have pointed to various reasons why this occurs in the United States, but one common finding is the fact that the United States spends far less on primary care and prevention than other OECD countries. Currently, the United States spends about 6 percent of its total health-care resources on primary care. By comparison, the United States spends 27 percent on inpatient hospitalization, 28 percent on outpatient hospital services, 30 percent on non-primary care professional procedures, and 16 percent on pharmaceuticals.

DEVELOPMENT OF METRICS IN MACRA

Question. I have heard from a number of physicians who believe that there is no link between many of the MIPS measures they are required to report and improving clinical care for their patients. I understand that the physician community has engaged with CMS to try and make the program more meaningful to physicians and patients through more relevant quality measures.

How are clinicians from your organization involved the creation of these measures relevant to their specialties?

Answer. The AAFP is participating in several CMS efforts to align measures and make measurement more meaningful, including the Core Quality Measures Collaborative, the Measures Application Partnership, the National Quality Forum, and efforts by measure developers to design measures applicable to primary care.

Current measures of primary care are scattered across all diseases, conditions, and preventive needs of patients; are generally indistinguishable from measures of other specialties; and do not adequately assess the quality of primary care. Primary care is much more complex than many people understand. Three out of four complaints that present are self-limited, and 40 percent of new symptoms do not lend themselves to any current coding system (*e.g.,* ICPC, ICD–10). In addition, the linear "assembly line" model that has resulted in some advances (*e.g.,* ventilator care) is not appropriate in primary care. Primary care requires a whole-person approach, prioritization of needs, a sophisticated primary care team, and consideration of the

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[14] *https://www.acep.org/uploadedFiles/ACEP/advocacy/ACEP%20Fair%20Coverage%20Report.pdf.*

[15] *https://www.ajmc.com/journals/issue/2013/2013-1-vol19-n12/medication-utilization-and-adherence-in-a-health-savings-accounteligible-plan.*

[16] *https://www.jhsph.edu/news/news-releases/2015/primary-care-visits-available-to-most-uninsured-but-at-a-high-price.html.*

[17] *https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0055491.*

[18] *https://www.hcup-us.ahrq.gov/reports/statbriefs/sb168-Hospital-Costs-United-States-2011.pdf.*

[19] *https://www.debt.org/medical/emergency-room-urgent-care-costs/.*

goals of the patient within the context of his or her social system. Additional research is needed on how primary care is delivered and how to improve and measure care in the primary care setting.

The AAFP is supportive of research, measure development, and measure testing being conducted by the Robert Graham Center and the VCU School of Medicine to develop meaningful measures of primary care, including measures of continuity, comprehensiveness, and the patient-centered primary care measure.

Question. Has CMS been receptive to your feedback when provided?

How would you assess CMS's collaboration on achieving meaningful metrics?

Answer. CMS along with other payers are collaborating with the Core Quality Measures Collaborative, but to date, implementation and acceptance by all payers is limited. Performance measures continue to be churned-out at high quantity by many organizations and remain unaligned and unfocused on the most important factors that impact health, health care, and costs, and administrative burden of reporting remains unacceptably high.

Question. Are there any changes in this process you would recommend?

Answer. Eliminate self-reporting of performance measures and rely on measures that are extracted from other sources. Please see discussion provided earlier. CMS could consider measuring care at a geographic area and attributing the measure result to all providers who treat patients from the area as a factor in their overall measure score (hospitals, clinics, individual physicians, subspecialists, CAH, RHC, etc.). Performance metrics derived from existing data sources that are most impactful should be calculated and applied as one factor of performance to all (*e.g.,* measures of access, SDoH, costs, and other factors that have a large impact on health of a population). This would support the need for addressing health/healthcare needs and costs at the system level and reduce silos of care.

Any single provider, facility, or patient might rightfully belong to multiple systems. For greatest impact, all populations and geographic areas must be attributed to one or more systems and all providers must be included in one or more systems, regardless of whether formal arrangements are in place. This is necessary to address issues of inequity, access, and cherry-picking, and would ensure that someone is responsible for the health, health care, and costs of all defined populations. Entities and health-care professionals could find themselves in overlapping systems with a competitor, which would encourage cooperation and mutual resource allocation to improve factors that influence health outcomes. Holding systems responsible for serving the needs of a geographic population may prevent the closure of clinics, EDs, maternity services, and other essential services in rural areas.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Accountable Care Organizations (ACOs) have the potential to transform our health care delivery system. While we've seen ACOs improve patient care and create shared savings, many provider-led ACOs only control a small fraction of total spending, with specialists, pharmaceuticals, and hospitals accounting for most of it. This leads to ACOs lacking sufficient leverage to bring down costs and can contribute to shared losses.

How can we improve the ACO model to account for this imbalance? How can we support successful ACOs and encourage more providers to follow their lead?

Answer. The AAFP supports the creation of more APMs for practices of all sizes to participate. We recommended that policymakers increase the glide path for new, low-revenue ACOs in the one-sided levels of the BASIC track to 3 years. This is supported by a recent study published by the *New England Journal of Medicine,* which found that, after 3 years in the MSSP, physician-led ACOs were able to generate shared savings that grew over the study period. It is imperative to allow ACOs, particularly physician-led and low-revenue ACOs, enough time to generate sufficient shared savings to offset startup costs and support sustained transformation.

We also encourage policymakers to maintain the shared savings rate at 50 percent for BASIC Levels A–D. We believe that a higher shared savings rate is necessary to support ACOs—especially physician-led and low-revenue ACOs with more limited capital reserves—in their efforts to improve quality and decrease costs.

Question. Our health-care system is not fully equipped to care for an aging population and patients with advanced illness such as late-stage cancer, Alzheimer's disease or dementia, or congestive heart failure. This is an area where we need new models of care that reflect these challenges and create a better system for providers, patients, and their families. Many of our current Medicare rules in this space are counterproductive, such as requiring a two night, three-day stay in an inpatient facility to qualify for skilled nursing care, and various disincentives to providing respite or palliative care. How are your organizations innovating to provide care for these patients, and what can Congress and CMS do to support those efforts?

Answer. The AAFP encourages CMS to continue waivers from its previous and existing programs, such as the SNF 3-day, telehealth, and home visit waivers. Additionally, CMS should work with Congress to create copay waivers. By waiving copays, practices would have more freedom to invest in primary care. Further, copays can often create barriers for beneficiaries to receive appropriate care and add administrative burden to practices as they try to collect copays. A copay waiver would reduce this administrative burden and encourage beneficiaries to seek the comprehensive and coordinated care provided by primary care physicians. Receiving timely, preventive care from primary care physicians is vital to improving the health of beneficiaries.

Question. Despite continued investment, electronic health records (EHRs) remain difficult to share, challenging for patients to access, and a source of frustration to providers and policymakers alike. The business models of the EHR venders often leads to perverse incentives against sharing patient information.

What steps can Congress take to make EHRs work better for providers? Are the proposed data blocking rules enough to start encouraging better data sharing by the vendors?

Answer. Electronic health records (EHRs) continue to pose significant challenges for all physicians and clinicians but especially for small and rural practices.[20] With fewer resources available, some rural practices use less expensive EHRs that have limited capabilities, which can make interoperability significantly more difficult. Additionally, EHRs often lack adequate technical support or may charge for providing basic user support. CMS' mandate to implement 2015 Edition certified EHR technology requires additional financial investments and staff support further inflate the barriers to successful value-based payment participation for rural practices. The AAFP welcomes the opportunity to partner with the committee as it considers ways to boost clinically meaningful HIT use among small practices.

The proposed data blocking rules are insufficient to better encourage data sharing by vendors. We encourage Senators to review the AAFP's response to HHS regarding the Interoperability and Patient Access proposed rule. The comment letter[21] expressed concern with proposed changes to drive the adoption of Application Programming Interfaces and trusted exchange within the health plan community—specifically, the requirement to make data available in one business day, and the recommendation that health plans amend contracts with physicians to require nearly real-time data submission, which would increase administrative burden on physicians. We also encourage Senators to review the AAFP's letter[22] on the proposed rule regarding interoperability and information blocking. The letter cautioned that the proposed framework would add unnecessary complexity and uncertainty for family physicians. The AAFP urged HHS to simplify the rules with small and medium-sized physician practices in mind.

Question. How can we encourage States to be better innovators on health-care spending? The current Medicaid waivers incentivize States to keep costs down, but are there ways to encourage both lower costs and better health-care outcomes?

Answer. Congress could encourage States to be better innovators on health-care spending and promote the adoption of APMs by addressing low Medicaid physician payment rates which have historically created a barrier to health-care access for Medicaid enrollees. AAFP policy[23] supports Medicaid payment for primary care services at least equal to Medicare's payment rate for those services when provided by a primary care physician. Accordingly, we urge Congress to resume Federal pri-

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[20] *https://www.gao.gov/assets/700/692179.pdf.*
[21] *https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/emr/LT-HHS-Interoperability-060319.pdf.*
[22] *https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/emr/LT-ONC-InfoBlocking060319.pdf.*
[23] *https://www.aafp.org/about/policies/all/medicaid-principles.html.*

mary care payment policy previously found in Medicaid—SSA 1902(a)(13)(C) and provide Federal funding to ensure a floor of Medicare payment rates for primary-care services in Medicaid.

QUESTIONS SUBMITTED BY HON. MAGGIE HASSAN

Question. We spoke during the hearing about the incentive payment for providers to improve tracking and reporting of opioid prescribing, treatment agreements, follow-up evaluations, and screening of patients who may be at risk of opioid misuse under the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA).

This data has the potential to improve treatment for substance use disorder, which is why its collection and reporting is now incentivized through increased reimbursement.

At the hearing, I asked for feedback on the impact this data collection and reporting has had on treatment of patients, particularly as it relates to any reduction in opioid misuse.

Based on your response, it seems that there may be additional steps the Centers for Medicare and Medicaid Services (CMS) could take so that this aggregated, de-identified data can be used to benefit patients and improve care.

Do you have specific suggestions on how CMS can improve the collection, use, and dissemination of opioid prescribing and treatment data sets in ways that would directly benefit patients at their site of care, specifically as it relates to identifying best practices to reduce opioid misuse?

Answer. In the AAFP's "Chronic Pain Management and Opioid Misuse" position paper,[24] we call on family physicians to use protocols for MAT to address opioid dependence within the clinic population. MAT for opioid and heroin dependence has existed for more than 5 decades and involves some form of opioid substitution treatment. Originally, only methadone (an opioid agonist) was available, but now clinicians have buprenorphine (a partial agonist used alone or in combination with naloxone) and naltrexone (an opioid antagonist with both oral and extended-release injectable formulations) as pharmacologic options for MAT. In addition, adjunctive medications such as clonidine, nonsteroidal anti-inflammatory medications (NSAIDs), and others are used in the treatment of specific opioid withdrawal symptoms.

With the increase in opioid misuse, various Federal and State authorities and professional organizations have produced guidelines to help providers best treat opioid use disorders. The AAFP encourages HHS to consult these resources and work toward a nationwide, comprehensive coverage of drugs used in MAT.

We applaud policymakers for encouraging health insurance plans to provide comprehensive coverage of MAT, opioid misuse and addiction is a serious national crisis. The AAFP calls for required, comprehensive coverage of MAT and counseling as recommended by the FDA in all public and private health insurance plans. Furthermore, the AAFP advocates against limits on MAT duration. Both FDA and SAMHSA state that treatment with MAT may be life-long, and we urge policymakers to factor that into MAT coverage policies.

QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO

Question. Nevada has one of the most significant health-care workforce shortages in the country. What kind of impact is MACRA having on the physician workforce? Are there ways to leverage the law to build that work force?

Answer. By moving Medicare payments away from fee-for-service, MACRA has a positive impact on those physicians that are able to participate in an APM. However, participation in MIPS continues to be burdensome and problematic for small and rural practices. Congress should encourage the proliferation of appropriate APMs to increase the physician workforce.

Question. MACRA included $20 million per year through 2020 to support the administration of technical assistance to help small and rural practices comply with

[24] *https://www.aafp.org/about/policies/all/pain-management-opioid.html.*

the law's reporting requirements. Almost $35 million will be left as of this coming January, to remain available until expended. As a contractor, can you explain the process of developing technical assistance?

Answer. The AAFP was not a contractor and did not develop technical assistance. Instead, we promoted the SURS to our members for their information. Congress provided technical assistance funds for CMS to support practices in MIPS. CMS created the Small, Rural, and Underserved Support (SURS). While these organizations have been helpful, they are unable to provide the in-depth and individualized support many small and rural practices need. The services provided [25] vary by each organization and may not be available to all practices. Additionally, the organizations can provide technical support, but they do not provide any financial or permanent human resources for practices. Stakeholders interviewed for a recent RAND report [26] felt the QPP support is able to provide high-level support, but much of the work cannot be done by outside contractors or office managers. Stakeholders also reported that the support providers sometimes lacked knowledge in certain areas or were unable to get answers from CMS to specific questions. Specifically, funds are needed to pay for IT support specific to individual users. Technical assistance providers lack specific IT knowledge and funds to implement real solutions.

Second, the AAFP would recommend the exceptional performance bonus payments be reimagined to reward practices that achieve significant year-over-year improvement versus rewarding those practices at the upper levels of annual performance. While we applaud these high-performing practices, it is our belief that additional positive payment adjustments would be better used if they were focused on rewarding the hard work of practices that achieve year-over-year improvements.

PREPARED STATEMENT OF MATTHEW FIEDLER, PH.D., FELLOW, USC–BROOKINGS SCHAEFFER INITIATIVE FOR HEALTH POLICY, BROOKINGS INSTITUTION

Chairman Grassley, Ranking Member Wyden, members of the Finance Committee, thank you for the opportunity to testify today. My name is Matthew Fiedler, and I am a fellow with the USC–Brookings Schaeffer Initiative for Health Policy, where my research focuses on a range of topics in health care economics and health care policy, including provider payment policy. Previously, I served as Chief Economist on the staff of the Council of Economic Advisers, where I provided economic advice on a range of health care policy issues. This testimony reflects my personal views and should not be attributed to the staff, officers, or trustees of the Brookings Institution.

I am honored to have the opportunity to speak with you about implementation of the Medicare physician payment provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[1] My testimony makes four main points:

1. Research examining the structure of the Merit-based Incentive Payment System (MIPS) and experience with similar programs suggest that MIPS is unlikely to improve the quality or efficiency of patient care. But MIPS is creating substantial administrative costs.
2. MACRA's bonus payments for clinicians participating in Advanced Alternative Payment Models (APMs) have great potential to increase participation in these models, which recent research has shown can reduce health care spending while maintaining or improving quality. Consistent with this potential, implementation of the bonus has coincided with—and likely helped cause—greater participation in advanced APMs, while also encouraging the Centers for Medicare and Medicaid Services (CMS) to deploy more effective APMs.
3. Policy-makers should build on what is working in MACRA and discard what is not by increasing the size of MACRA's incentives for participation in Ad-

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[25] *https://www.gao.gov/assets/690/681541.pdf.*

[26] *https://www.rand.org/content/dam/rand/pubs/research_reports/RR2800/RR2882/RAND_RR2882.pdf.*

[1] Many of the ideas discussed here were developed in joint work with several colleagues. *See* Fiedler, Matthew, Tim Gronniger, Paul B. Ginsburg, Kavita Patel, Loren Adler, and Margaret Darling. 2018. "Congress Should Replace Medicare's Merit-Based Incentive Payment System." *Health Affairs Blog. https://www.healthaffairs.org/do/10.1377/hblog20180222.35120/full/*. Any errors are my own.

vanced APMs, creating similar incentives for other categories of providers, and eliminating MIPS.

4. In the absence of broader changes to MACRA, several narrower reforms are worth considering. These include making the advanced APM bonus permanent, eliminating the "cliff" in the Advanced APM bonus eligibility rules, standardizing the measures used in the MIPS quality category, and replacing the MIPS practice improvement and promoting interoperability categories with more targeted incentives.

BACKGROUND ON MACRA

In addition to reauthorizing the Children's Health Insurance Program and repealing the sustainable growth rate formula that determined the overall level of Medicare's physician payment rates, MACRA made important structural changes to how Medicare pays physicians. Under MACRA, clinicians choose between two tracks: (1) participating in MIPS; and (2) participating in an Advanced APM.

Most clinicians are currently participating in MIPS, which adjusts clinicians' payment rates upward or downward based on their performance in four categories: (1) quality of care; (2) cost of care; (3) completion of specified "practice improvement" activities; and (4) use of certified electronic health records (EHRs), now called the Promoting Interoperability category by CMS. In the quality and practice improvement categories, clinicians have broad flexibility to select the measures or activities they are evaluated on. With the exception of the cost category, clinicians are generally responsible for collecting the information used to evaluate their performance and submitting that information to CMS. The first "performance year" under MIPS was 2017; payment adjustments for the 2017 performance year are occurring during 2019.

Clinicians are permitted to opt out of MIPS if they participate to a sufficient degree in an Advanced APM, as measured by the share of a clinician's payments or patient volume connected with an Advanced APM.[2] Importantly, clinicians with sufficient participation in Advanced APMs are also eligible for a bonus payment equal to 5 percent of their physician fee schedule revenue. Paralleling MIPS, the first performance year for the Advanced APM bonus was 2017, and the first bonus payments are occurring in 2019. The bonus for Advanced APM participation will expire after the 2022 performance year.[3]

To be considered an Advanced APM, a payment model must make participants financially liable if spending exceeds an expected level. Advanced APMs must also must base payment in part on participants' quality performance and require participants to use an EHR that meets the certification criteria promulgated by the Department of Health and Human Services (HHS). The most prominent examples of Advanced APMs are Accountable Care Organization (ACO) models that include "two-sided" risk (that is, ACO models that require participants to bear a portion of the costs if spending by their beneficiaries exceeds the "benchmark" spending level under the model). However, some episode (or "bundled") payment models, as well as some medical home models, also qualify as Advanced APMs.

MIPS APPEARS UNLIKELY TO MEANINGFULLY IMPROVE PATIENT CARE, BUT IS CREATING BURDEN

There is limited direct evidence on MIPS's effects to date because data on the program's first year were only recently released and because decisions CMS made to ease the transition to MIPS make this early experience a poor guide to how MIPS will perform in the long run. However, analyses of MIPS's structure, as well as research examining prior similar programs, suggest that MIPS is unlikely to achieve its goals of reducing costs or improving quality. Nevertheless, MIPS is creating significant administrative costs for providers.

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[2] For the current performance year, a clinician must serve at least 35 percent of its patients or receive at least 50 percent of its payments in connection with an Advanced APM. For 2021 and later performance years, those thresholds rise to 50 percent and 75 percent, respectively. Clinicians with somewhat lesser engagement with Advanced APMs are eligible to opt out of MIPS but are not eligible for bonus payments.

[3] MACRA provides that payment rates for clinicians participating in Advanced APMs will grow 0.5 percentage points per year more quickly than those for non-participants starting with the 2024 performance year, which will gradually re-create an incentive for participation in Advanced APMs. However, it will take more than a decade after 2022 before incentives for participation in Advanced APMs return to the level of the current bonus.

Structural Problems Limit MIPS's Ability to Improve the Quality or Efficiency of Patient Care

MIPS has several structural problems that limit the program's ability to improve the quality or efficiency of the care Medicare beneficiaries receive. I focus on three that are particularly significant. Other experts and the Medicare Payment Advisory Commission (MedPAC) have expressed similar concerns about MIPS's architecture.[4]

Problem #1: Orienting Payment Incentives Around Clinicians, Rather Than Patients

MIPS aims to improve the quality and efficiency of patient care by adjusting payments for individual clinicians or practices. But a given patient's care often involves multiple different clinicians, each playing a different role. Ensuring that the payment incentives MIPS creates for individual clinicians or practices add up to a coherent set of incentives for the management of each patient's care is at best difficult and, as a practical matter, probably impossible.

For example, under the MIPS cost category as currently implemented, the need to measure cost performance at the clinician or practice level has led CMS to create multiple different cost measures, score each clinician or practice on all measures for which minimum sample size requirements are met, and then compute a final category score as an equally weighted average of the scored measures. This approach creates an unpredictable and haphazard overall set of incentives to reduce spending since a given dollar of spending may factor into zero, one, or more than one of the cost measures that end up being scored for any given provider.

Problem #2: Limited Panel Sizes at the Practice Level

It is difficult to reliably measure cost or quality performance at the level of an individual clinician or practice because of the relatively small number of Medicare beneficiaries involved. This problem is particularly acute when measuring cost performance since health care spending varies so widely across individuals. As a result, at least once MIPS is fully implemented, chance will play a large role in determining where a clinician falls on the spectrum of possible payment adjustments under MIPS, which weakens the incentives those payment adjustments create for clinicians to improve performance. Incentives could, of course, be strengthened by making the MIPS payment adjustments larger, but clinicians would have legitimate concerns about basing large payment adjustments on performance measures influenced so strongly by random chance.

Problem #3: Clinician Choice of Quality Measures

Clinicians' ability to choose the quality measures they are evaluated on undermines the effectiveness of the MIPS quality category. Allowing clinicians to choose quality measures was a well-intended effort to allow clinicians to tailor the measures they report to the nature of the care they provide. However, the lack of common measures makes comparing the performance of different clinicians—even clinicians providing similar services—difficult or impossible. That, in turn, makes it hard to determine which clinicians are, in fact, high or low performers for the purposes of MIPS payment adjustments. The lack of common measures will also make it difficult or impossible for patients to use the data generated by MIPS to compare providers.

Allowing choice also creates strong incentives for clinicians to selectively report quality measures on which they perform well while declining to report measures on which they perform poorly. Indeed, due to the financial stakes under MIPS, it is hard for clinicians to avoid doing this, even if that would be their preference. This type of selective reporting causes the data collected under MIPS to provide a skewed picture of each clinician's performance, making it even more difficult for patients or CMS to use the data to evaluate clinicians. These incentives for selective reporting likely also increase administrative costs by requiring providers to invest time and effort (or hire consultants) to identify the measures they are likely to perform best on, or, alternatively, to collect data on many more measures than they are required to report and submit only the best ones.

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[4] *See, for example,* Schneider, Eric C. and Cornelia J. Hall. 2017. "Improve Quality, Control Spending, Maintain Access—Can the Merit-based Incentive Payment System Deliver?" *New England Journal of Medicine* 376(8): 708–710; Medicare Payment Advisory Commission. 2018. "Moving Beyond the Merit-based Incentive Payment System." *http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch15_sec.pdf?sfvrsn=0;* Rathi, Vinay K. and J. Michael McWilliams. 2019 "First-Year Report Cards From the Merit-Based Incentive Payment System (MIPS): What Will Be Learned and What Next?" *Journal of the American Medical Association.*

The MIPS practice improvement activities category suffers from similar problems. Practices are permitted to select from a list of more than 100 practice improvement activities and can achieve a maximum score by completing at most four (and sometimes fewer) activities.[5] The list is sufficiently broad that, at least in many instances, clinicians can achieve the maximum score for the practice improvement category by reporting on activities that they had already planned to complete. In those instances, the practice improvement category creates reporting costs for providers, but no benefit to patients. Even when the category does induce providers to take action they would not otherwise have taken, the benefit to patients is uncertain. While many of the included activities are at least superficially appealing, the evidence base supporting them is not always clear, nor is it clear that the level of engagement with these activities required to gain credit under MIPS is sufficient to generate meaningful changes in care.

Research on Programs Similar to MIPS Has Found Discouraging Results

MIPS is not the first instance in which Medicare has sought to improve the quality or reduce the cost of patient care by adjusting providers' fee-for-service payment rates upward or downward based on performance on a broad set of cost and quality measures. Research on these similar programs has found little evidence that such programs have achieved their objectives, and there is little reason to believe that a different result should be expected under MIPS.

A recent study examining the Value-Based Payment Modifier (Value Modifier), a predecessor to MIPS that adjusted Medicare payment rates for physician groups based on cost and quality performance, provides particularly relevant and compelling evidence.[6] This research draws on the fact that practices with 100 or more clinicians could receive either bonuses or penalties under the Value Modifier, while practices with between 10 and 99 clinicians could receive only bonuses and smaller practices were excluded entirely. The researchers were thus able to isolate the effect of the Value Modifier by looking for sharp changes in cost or quality performance at these practice size thresholds. The authors found no evidence that the Value Modifier had any effect on potentially avoidable hospitalizations, hospital readmissions, Medicare spending, or mortality.

Research examining the Hospital Value-Based Purchasing Program (HVBP), which adjusts Medicare hospital payments upward and downward based on a similarly broad set of measures, has reached similar discouraging conclusions.[7] The same is true of research on the Premier Hospital Demonstration, a demonstration project that was a predecessor of the HVBP.[8] It is notable that these hospital-focused programs avoid at least some of MIPS's shortcomings since most hospitals have much higher patient volumes than individual clinicians or practices and these programs do not allow hospitals to choose which measures they are evaluated on.

Before proceeding, I note two caveats on this evidence. First, the estimates from these studies are subject to some uncertainty. Thus, while this evidence largely rules out the possibility that these programs caused large improvements in patient care, these programs could have caused smaller improvements in patient care that these studies were unable to detect.

Second, this evidence should not be interpreted as showing that adjusting payments based on particular outcomes within a fee-for-service structure can never be successful. Notably, research on the Hospital Readmission Reduction Program (HRRP), which penalizes hospitals at which a large share of patients are readmitted

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[5] Practice improvement activities include items like reporting to clinical registries, conducting a survey on patient satisfaction, participating in specific trainings, or integrating recommended clinician screenings into routine practice.

[6] Roberts, Eric T., Alan M. Zaslavsky, and J. Michael McWilliams. 2018. "The Value-Based Payment Modifier: Program Outcomes and Implications for Disparities." *Annals of Internal Medicine* 168(4): 255–265.

[7] Ryan, Andrew M., Sam Krinsky, Kristin A. Maurer, and Justin B. Dimick. 2017. "Changes in Hospital Quality Associated With Hospital Value-Based Purchasing." *New England Journal of Medicine* 376(24): 2358–2366; Figueroa, Jose F., Yusuke Tsugawa, Jie Zheng, E. John Orav, and Ashish K. Jha. 2016. "Association between the Value-Based Purchasing pay for performance program and patient mortality in US hospitals: observational study." *British Medical Journal* 353: i2214.

[8] Jha, Ashish K., Karen E. Joynt, E. John Orav, and Arnold M. Epstein. 2012. "The Long-Term Effect of Premier Pay for Performance on Patient Outcomes." *New England Journal of Medicine* 366(17): 1605–1615.

soon after discharge finds that it substantially reduced hospital readmission rates.[9] Moreover, while there has been some recent controversy on this point, there is, in my view, some evidence that the HRRP reduced post-discharge mortality rates and no compelling evidence that the HRRP increased mortality.[10] One plausible explanation for why the HRRP has been more successful than the Value Modifier or HVBP is that the HRRP is a much more targeted program that attaches relatively strong incentives to a narrow set of outcomes.

Providers Incur Significant Costs to Comply With MIPS

While MIPS, at least in its current form, appears unlikely to substantially improve patient care, it is creating substantial compliance costs. For the 2019 performance year, CMS estimates that providers will incur $482 million in reporting costs related to MIPS, with the MIPS quality category accounting for the majority of those costs.[11] Notably, this figure does not include the costs providers incur to develop a strategy for complying with MIPS, including deciding which quality measures it is most advantageous to collect and report. These activities are likely to require providers to invest substantial staff time, hire outside consultants, or both.

Of course, the fact that complying with MIPS creates administrative costs is not, in itself, evidence of a problem. If MIPS was improving the quality or efficiency of patient care, then these costs could be worth incurring. Indeed, the $482 million in estimated reporting costs cited above constitute only around 0.5 percent of projected spending on services under the physician fee schedule during 2019, so even modest improvements in care could suffice. But it is hard to justify requiring clinicians to incur these costs in service of an ineffective program.

RESEARCH FINDS APMS CAN BE EFFECTIVE, AND PARTICIPATION IN ADVANCED APMS IS RISING

While I am pessimistic about MIPS, I am optimistic about MACRA's bonus payments for participation in Advanced APMs. Recent research has shown that well-designed APMs can reduce health-care spending while maintaining or improving quality. Furthermore, implementation of MACRA's bonus payments has coincided with—and likely helped cause—an increase in participation in these models, while also facilitating the deployment of more effective APMs.

Evidence on APMs' Effectiveness

Recent research indicates that APMs can be effective tools for reducing health-care spending. I focus on the evidence on ACO models since they account for the large majority of participation in APMs and advanced APMs in Medicare. The best such research has focused on the Medicare Shared Savings Program (MSSP), which is by far the largest Medicare ACO program.[12] This research has found that MSSP ACOs reduce average spending per beneficiary by between 0 and 5 percent, with the size of the spending reduction depending on an ACO's composition and how long it has participated in the MSSP. On average, physician-group ACOs that have a few years of experience in the MSSP have performed at the high end of this range, while ACOs containing a hospital have performed at the low end of this range. Research examining the Center for Medicare and Medicaid Innovation's Pioneer ACO model has also found evidence that the model reduced spending, as has research examining a commercial ACO-like contract operated by Blue Cross Blue Shield of Massachusetts.[13]

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[9] Zuckerman, Rachael B., Steven H. Sheingold, E. John Orav, Joel Ruhter, and Arnold M. Epstein. 2016. "Readmissions, Observation, and the Hospital Readmission Reduction Program." *New England Journal of Medicine* 374: 1543–1551; Medicare Payment Advisory Commission. 2018. "Mandated report: The effects of the Hospital Readmissions Reduction Program." *http://www.medpac.gov/docs/default-source/reports/jun18_ch1_medpacreport_sec.pdf;* Atul Gupta. 2017. "Impact of performance pay for hospitals: The Readmissions Reduction Program." Working Paper. *https://www.dropbox.com/s/rfwok9en2c5812j/Gupta_HRRP.pdf.*

[10] *Ibid.*

[11] *See* Table 91 in Centers for Medicare and Medicaid Services. 2018. "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019." Federal Register 83(226): 59452. *https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf.*

[12] McWilliams, J. Michael, Laura A. Hatfield, Bruce E. Landon, Pasha Hamed, and Michael E. Chernew. 2018 "Medicare Spending After 3 Years of the Medicare Shared Savings Program." *New England Journal of Medicine* 379(12): 1139–1149.

[13] McWilliams, J. Michael, Michael E. Chernew, Bruce E. Landon, and Aaron L. Schwartz. 2015. "Performance Differences in Year 1 of Pioneer Accountable Care Organizations." *New England Journal of Medicine* 372(20): 1927–1936; Nyweide, David J., Woolton Lee, Timothy T. Cuerdon, Hoangmai H. Pham, Megan Cox, Rahul Rajkumar, Patrick H. Conway. 2015. "Associa-

For a few reasons, I suspect these findings may understate the overall savings that should be expected from ACO models, at least over the long run. First, the research cited above provides some evidence that providers perform better in these models as they gain experience. Second, the research on MSSP examines years in which essentially all ACOs were participating in one-sided models under the program's original benchmarking methodology; as discussed below, CMS has made changes in both these areas that will likely cause MSSP ACOs to have stronger incentives to reduce spending in the future than they have in the past. Third, these models may reduce spending through a variety of channels that were not examined in these studies. Most directly, reductions in traditional Medicare spending reduce payments to plans under the Medicare Advantage program.[14] Medicare's deployment of these models also appears to have coincided with—and plausibly helped cause—increased use of these models by private insurers.[15] Providers participating in ACOs may also change the way they treat patients covered by other payers or play a role in reshaping the practice norms adhered to by other providers.[16]

It is less clear how ACOs have affected quality of care, in part because measuring changes in quality of care is more difficult. There is reasonably persuasive evidence that the savings achieved under Medicare's ACO models have not come at the cost of worse health outcomes.[17] What is less clear is whether ACO models have actually improved quality of care and, if so, by how much. There is some evidence that ACOs have improved patients' experience of care.[18] Some research has also suggested that ACOs have increased receipt of certain recommended screenings services, but this finding has been inconsistent.[19] More research on this question would be valuable.

An important question is why ACOs have performed better than pay-for-performance programs like MIPS, at least with respect to the cost of care. I suspect two factors are important. First, an ACO serves many more patients than an individual clinician or practice. That larger size makes it much easier to produce statistically reliable measures of providers' performance, which in turn allows ACOs to use payment designs that create much stronger incentives to reduce spending than programs like MIPS. Second, ACOs make one provider (or group of providers) accountable for the overall cost and quality of a patient's care. That allows ACOs to create much more coherent—and comprehensible—incentives to improve patient care than programs like MIPS that make disconnected payment adjustments for each individual provider.

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tion of Pioneer Accountable Care Organizations vs Traditional Medicare Fee for Service With Spending, Utilization, and Patient Experience." *Journal of the American Medical Association* 313(21): 2152–2161; Song, Zirui, Sherri Rose, Dana G. Safran, Bruce E. Landon, Matthew P. Day, and Michael E. Chernew. 2014. "Changes in Health Care Spending and Quality 4 Years Into Global Payment." *New England Journal of Medicine* 371(18): 1704–14.

[14] Centers for Medicare and Medicaid Services. 2018. "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success and Extreme and Uncontrollable Circumstances Policies for Performance Year 2017." Federal Register 83(249): 67816; McWilliams, J. Michael. 2016. "Savings From ACOs—Building on Early Success." *Annals of Internal Medicine* 165(12): 873–875.

[15] Muhlestein, David, Robert S. Saunders, Robert Richards, and Mark B. McClellan. 2018. "Recent Progress in the Value Journey: Growth of ACOs and Value-Based Payment Models in 2018." *Health Affairs Blog. https://www.healthaffairs.org/do/10.1377/hblog20180810.481968/full/*.

[16] Baicker, Katherine, Michael E. Chernew, and Jacob A. Robbins. 2013. "The spillover effects of Medicare managed care: Medicare Advantage and hospital utilization." *Journal of Health Economics* 32(6): 1289–1300; Glied, Sherry and Joshua Graff Zivin. 2002. "How do doctors behave when some (but not all) of their patients are in managed care?" *Journal of Health Economics* 21(2): 337–353; McWilliams, J. Michael, Bruce E. Landon, Michael E. Chernew. 2013. "Changes in Health Care Spending and Quality for Medicare Beneficiaries Associated With a Commercial ACO Contract." *Journal of the American Medical Association* 310(8): 829–836.

[17] Herrel, Lindsey A., Edward C. Norton, Scott R. Hawken, Zaojun Ye, Brent K. Hollenbeck, and David C. Miller. 2016. "Early Impact of Medicare Accountable Care Organization Cancer Surgery Outcomes." *Cancer* 122(17); 2739–2746; McWilliams, J. Michael, Lauren G. Gilstrap, David G. Stevenson, Michael E. Chernew, Haiden A. Huskamp, and David C. Grabowski. 2017. "Changes in Post-acute Care in the Medicare Shared Savings Program." *JAMA Internal Medicine* 177(4): 518–526.

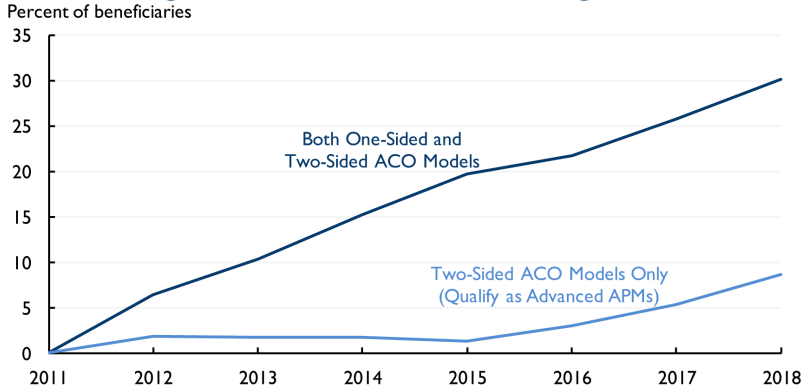
[18] McWilliams, J. Michael, Bruce E. Landon, Michael E. Chernew, and Alan M. Zaslavsky. 2014. "Changes in Patients' Experiences in Medicare Accountable Care Organizations." *New England Journal of Medicine* 371(18): 1715–1724.

[19] McWilliams et al. (2015); McWilliams, J. Michael, Laura A. Hatfield, Michael E. Chernew, Bruce E. Landon, and Aaron L. Schwartz. 2016. "Early Performance of Accountable Care Organizations in Medicare." *New England Journal of Medicine* 374(24): 2357–2366.

Advanced APM Participation Has Risen Markedly in Recent Years

Participation in APMs that meet the Advanced APM criteria has increased markedly since MACRA's enactment. Figure 1 presents data on participation in ACOs, which, as noted above, account for the large majority of APM and Advanced APM participation in Medicare.[20] The share of Medicare beneficiaries served by providers that participate in an ACO that involves "two-sided" risk—the types of ACO models that qualify as Advanced APMs—stood at 9 percent in 2018, up from 3 percent in 2016, the last year before the Advanced APM bonus became available. Advanced APM participation also increased from 2015 to 2016, from 1 percent to 3 percent, and it is possible that a portion of this increase occurred because providers were anticipating the fact that bonuses for Advanced APM participation would become available in 2017.

Figure 1: Share of Traditional Medicare Beneficiaries Assigned to an Accountable Care Organization



Source: Author's calculations based on CMS data.
Note: Estimates are for the end of the calendar year. Estimates for 2018 are based on preliminary data.

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Additional research on why participation in two-sided ACO models has risen in recent years would be valuable, but I suspect that the Advanced APM bonus has played an important role. That said, the bonus payment is likely not the only factor. Notably, CMS has recently been expanding its portfolio of two-sided ACO models: in 2016, CMS introduced the Track 3 participation option under the MSSP and introduced the Next Generation ACO model under the auspices of the Center for Medicare and Medicaid Innovation; and, in 2018, CMS introduced the Track 1+ participation option under the MSSP, an option that includes "two-sided" risk, but in a more limited form than prior models. Providers have also gained experience with ACO models over time, which may make them more willing to take on two-sided risk.

MACRA's Advanced APM Bonus Has Supported Deployment of More Effective APMs

The existence of the Advanced APM bonus has also encouraged CMS to be more aggressive in deploying ACO models that create stronger incentives for providers to reduce health-care spending. This is the case in at least two areas.

First, in 2016, CMS finalized changes to the rules for calculating the spending "benchmarks" used to evaluate MSSP ACOs' spending performance. Prior to this

[20] These estimates include beneficiaries assigned to ACOs participating in the Medicare Shared Savings Program or the Center for Medicare and Medicaid Innovation's Pioneer and Next Generation ACO models. Estimates use the MSSP public use files produced by CMS, as well as the published financial results for the Pioneer and Next Generation models. Enrollment data are not yet available for 2018, but the number of ACOs participating in each program is available, so I have assumed that the number of beneficiaries assigned to each type of ACO grew in proportion to the number of ACOs of that type. Track 1+ did not exist as an MSSP participation option until 2018, so I assume that the average number of beneficiaries assigned to each Track 1+ ACO in 2018 was the same as the average number of beneficiaries assigned to each Track 1 ACO in 2017.

change, benchmarks for MSSP ACOs were set based on each ACO's own spending over the 3 years preceding each agreement period. This methodology greatly weakened ACOs' incentives to reduce spending since success in reducing spending during an ACO's current agreement period was penalized by a dollar-for-dollar reduction in the ACO's benchmark for the subsequent agreement period.

To ameliorate this problem, CMS changed the benchmark calculation so that each ACO's benchmark equaled a blend of the ACO's own past spending and average spending in the ACO's region.[21] The revised methodology has the downside, however, of making MSSP participation less attractive for ACOs with high spending relative to their regions. The upward pressure on ACO participation from implementation of the Advanced APM bonus helped counteract the downward pressure on participation among high-cost ACOs from the benchmarking change and likely made CMS more willing to implement these improvements to the benchmarking methodology.

Second, in late 2018, CMS finalized rules that will require all ACOs to shift into models that include two-sided risk more quickly than had been required under prior rules.[22] Like the benchmarking change, this policy change involves a tradeoff. Models that include two-sided risk create stronger incentives for providers to reduce spending and, even holding underlying health care spending constant, directly generate larger savings for the Medicare program. Models with two-sided risk are also, however, less attractive to providers (all else being equal), so requiring two-sided risk is likely to put downward pressure on ACO participation. The existence of the Advanced APM bonus appears to have shaped how CMS weighed these tradeoffs and made it more willing to move ahead, which was, in my view, the right decision, although it was a close call.[23]

THE BEST PATH FORWARD: ELIMINATE MIPS AND STRENGTHEN ADVANCED APM INCENTIVES

Policymakers should seek to build on the parts of MACRA that are working well, while discarding the parts that are not. To that end, I believe that the best path forward is to eliminate MIPS, but expand incentives for participation in Advanced APMs. I will discuss each recommendation in turn.

Recommendation #1: Eliminate MIPS

In light of the problems with MIPS discussed earlier, I agree with MedPAC and other experts that eliminating MIPS is the best path forward.[24] Some of MIPS's problems—particularly those stemming from clinicians' ability to choose the quality measures they are evaluated on—could be addressed while retaining MIPS's basic structure. However, many of MIPS's issues are more fundamental. In particular, generating statistically reliable measures of cost and quality performance at the practice level is likely effectively impossible, as is creating coherent overall incentives to improve patient care by adjusting payments to individual physician practices.

These challenges, together with the evidence that prior programs similar to MIPS have not been effective, lead me to believe that a reformed MIPS would still fail to generate improvements in the quality or efficiency of patient care sufficient to justify its administrative costs. I thus view eliminating MIPS as the best path for-

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[21] Centers for Medicare and Medicaid Services. 2016. "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Revised Benchmark Rebasing Methodology, Facilitating Transition to Performance-Based Risk, and Administrative Finality of Financial Calculations." Federal Register 81(112): 37950.

[22] Centers for Medicare and Medicaid Services. 2018. "Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success and Extreme and Uncontrollable Circumstances Policies for Performance Year 2017." Federal Register 83(249): 67816.

[23] For additional discussion of my views on these changes, *see* Fiedler, Matthew. 2018. "Comments on CMS's Proposed Rule, 'Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success.'" *https://www.brookings.edu/opinions/comments-on-cmss-medicare-shared-savings-program-accountable-care-organizations-pathways-to-success/*. For a thoughtful opposing view, see McWilliams, J. Michael, Michael Chernew, and Bruce Landon. 2018. "Comment Letter on MSSP Proposed Rule." *https://hmrlab.hcp.med.harvard.edu/mcwilliams-chernew-and-landon-comment-mssp-proposed-rule.*

[24] *See, for example,* Medicare Payment Advisory Commission. 2018. "Moving Beyond the Merit-based Incentive Payment System." *http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch15_sec.pdf?sfvrsn=0;* Rathi, Vinay K. and J. Michael McWilliams. 2019 "First-Year Report Cards From the Merit-based Incentive Payment System (MIPS): What Will Be Learned and What Next?" *Journal of the American Medical Association.*

ward. If MIPS were eliminated, policymakers should consider creating targeted incentives for use of certified EHRs and reporting to clinical registries; I discuss such incentives later in this testimony in the section on potential incremental changes to MIPS.

Recommendation #2: Strengthen Incentives for Advanced APM Participation

In contrast to MIPS, MACRA's incentive for participation in Advanced APMs appears to be achieving its main goal of increasing participation in effective alternative payment models. Policymakers should seek to build on the success of this component of MACRA by strengthening incentives for participation in Advanced APMs.

Creating stronger incentives for participation in Advanced APMs would have two benefits. First, stronger incentives for Advanced APM participation would directly increase participation in these models, which the research reviewed earlier indicates would increase the efficiency of Medicare spending while maintaining or improving the quality of the care Medicare beneficiaries receive. Second, stronger incentives for participation in Advanced APMs would allow CMS to make further progress in deploying versions of APMs that create stronger incentives to reduce spending. In particular, it will likely ultimately be desirable for CMS to go further in requiring ACOs to take on two-sided risk and in basing ACOs' "benchmarks" on regional average spending rather than ACOs' own historical costs. However, as noted earlier, changes like these make ACO participation less attractive for some categories of providers. Sufficiently strong incentives for Advanced APM participation could mitigate or eliminate this tradeoff.

A good first step to strengthen incentives for participation in Advanced APMs would be to make MACRA's bonus for participation in Advanced APMs permanent, a point I return to in the next section of my testimony. However, more significant enhancements are warranted:

- *Increase the size of the incentive for Advanced APM participation:* One worthwhile step would be to increase the size of MACRA's incentives for participation in Advanced APMs.

  Determining the appropriate magnitude of the increase would require additional modeling and analysis, but creating an incentive for Advanced APM participation that is at least twice as large as the current incentive could easily be appropriate.

  Since a major objective of promoting greater participation in Advanced APMs is to reduce Medicare spending, additional incentives for Advanced APM participation should be structured in a way that does not increase Federal costs. To that end, Congress could implement a budget-neutral combination of larger bonuses for Advanced APM participation and penalties for providers that decline to participate in an Advanced APM. This approach of using penalties from poor performers to fund bonus payments to high performers is similar to the approach Congress has taken under MIPS and many other programs.

- *Create incentives for other categories of providers to participate in Advanced APMs or collaborate with participants in Advanced APMs:* An additional worthwhile step would be to create incentives for other categories of providers, particularly hospitals, to participate in Advanced APMs or collaborate with providers who participate in Advanced APMs. Providers could qualify for incentive payments in essentially the same way that clinicians can qualify under MACRA, with the exception that providers could count services or patients associated with an Advanced APM in which the provider was not itself participating if the provider had a written collaboration agreement with participants in that Advanced APM. This approach would, for example, allow a hospital to earn the incentive payment by collaborating with one or more physician-only ACOs in its community rather than setting up its own ACO. Allowing hospitals to take this approach is particularly important in light of the evidence noted above that physician-only ACOs have been more successful in reducing spending than those containing a hospital as a participant.

  There are two reasons to extend Advanced APM incentives to non-physician providers. First, it would give these providers a greater stake in the deployment and success of Advanced APMs, which may be necessary to fully realize these models' potential to improve the quality and efficiency of patient care. Second, there are likely limits on how low payment rates for clinicians not participating in Advanced APMs can be set, which limits the overall size of the incentives that can be created for Advanced APM participation if the phy-

sician fee schedule is the sole vehicle for creating those incentives. Extending incentives for Advanced APM participation for other providers relaxes this constraint.

As above, it would be important that additional incentives for Advanced APM participation be structured in a way that would not increase Federal costs. To this end, any incentive for hospitals or other categories of providers could be structured as a budget-neutral combination of bonuses for participants and penalties for non-participants.

INCREMENTAL STEPS: EXTEND THE ADVANCED APM BONUS AND MAKE TARGETED MIPS CHANGES

While eliminating MIPS and expanding MACRA's Advanced APM incentives is the best path forward in my view, there are also opportunities to make incremental improvements in both areas.

Permanently Extend the Advanced APM Bonus and Eliminate the Eligibility "Cliff"

There are at least two incremental changes that could be made to the Advanced APM bonus:

- *Permanently extend the Advanced APM bonus:* One important step Congress can take is to permanently extend the Advanced APM bonus, which is currently scheduled to expire after the 2022 performance year. It would be best to enact an extension well before the bonus expires. Many of the investments providers need to make to be successful under Advanced APMs are only likely to be attractive to providers that expect to continue participating in Advanced APMs in the future, and the likelihood that the Advanced APM bonus will continue is one major factor shaping providers' plans about future APM participation. Waiting until the last minute to extend the bonus would thus likely reduce Advanced APM participation in the near term and forfeit a portion of the bonus's potential benefits.

  The Advanced APM bonus can and should be extended in a way that does not increase overall Medicare spending. One approach to achieving this objective, discussed above, would be to replace the current bonus payment with a budget-neutral combination of bonuses for Advanced APM participation and penalties for non-participation. Another approach would be to pair the extension with offsetting changes to Medicare payments.

- *Smooth out the "cliff" in the Advanced APM bonus eligibility criteria:* A clinician's eligibility for the Advanced APM bonus depends on whether a sufficient share of its payments or patient volume is connected with an Advanced APM. Clinicians that exceed the threshold are eligible for the full bonus, while clinicians that fall short, even by a very small amount, are eligible for no bonus payments at all.

  This "all or nothing" structure is hard to justify. The Medicare program frequently benefits from clinician engagement with Advanced APMs even when that engagement falls short of the eligibility thresholds; that will be particularly true under the relatively high eligibility thresholds that will apply over the long run. Additionally, the Medicare program would sometimes benefit if clinicians that meet the current thresholds had incentives to further increase their engagement with Advanced APMs.

  Thus, it would be desirable to replace the current "all or nothing" structure with a structure in which a clinician's bonus phased up gradually once a clinician's engagement with Advanced APMs crossed a threshold level. Under such an approach, it would be important that the bonus payment phase in rapidly enough to ensure that clinicians currently receiving bonuses generally received bonuses comparable to those they receive today. This approach has similarities to a proposal included in the administration's fiscal year 2020 budget, but there are two important differences.[25] First, the administration's proposal appears to reduce bonuses for many current recipients, which would be a step in the wrong direction. Second, the administration's proposal would pay bonuses to some providers with very limited Advanced APM engagement, which is likely a low-priority use of bonus funds.

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[25] Department of Health and Human Services. 2019. "Fiscal Year 2020 Budget-in-Brief." *https://www.hhs.gov/sites/default/files/fy-2020-budget-in-brief.pdf.*

Make Targeted Improvements to MIPS

As noted earlier, I believe there are limits to what a reformed MIPS program could realistically achieve. But there are three changes that I believe would improve MIPS's performance:

- *Standardize quality measures:* The problems that arise from clinicians' ability to choose quality measures under MIPS could be addressed by directing CMS to establish standardized measure sets for each specialty (or subspecialty) and requiring clinicians to report those standardized measure sets. The applicable measure set could be determined from claims data based on the mix of services a clinician delivered.[26]

  Particularly initially, it is likely that some clinicians would lack a standardized measure set appropriate to their practice. For these clinicians, the quality category could be excluded from scoring under MIPS. Excluding the quality category would be preferable to requiring clinicians to incur the costs necessary to continue reporting under the current system since such reporting appears unlikely to meaningfully benefit Medicare beneficiaries.

  CMS could be directed to collaborate with other payers in constructing these specialty-specific standardized measure sets, to the extent feasible, in order to reduce administrative burden for providers. CMS is already engaged in such a process via the Core Quality Measures Collaborative operating under the auspices of the National Quality Forum.

  An alternative approach to reforming the MIPS quality category would be to eliminate the requirement that clinicians report quality measures and instead rely on measures derived from claims records or beneficiary surveys. The administration's fiscal year 2020 budget and MedPAC have both put forward proposals in this vein.[27] This approach would generate large reductions in clinicians' reporting burdens and is worth considering. However, even with this change, I expect that MIPS would remain an ineffective tool for improving the quality and efficiency patient care, so if Congress is willing to consider changes this large, I would encourage it to consider eliminating MIPS entirely.

- *Eliminate the practice improvement category and create a targeted incentive for reporting to clinical data registries:* The MIPS practice improvement category is essentially a "box checking" exercise that is doing little to improve patient care but is creating reporting costs for clinicians. I recommend eliminating this category.

  That said, there may be some specific activities currently included on the list of practice improvement activities that are worth encouraging. Notably, clinician reporting to clinical data registries has features of a "public good." Reporting to registries generates benefits for the health care system as a whole by facilitating research on ways to improve patient care and allowing clinicians to compare themselves to their peers.

  To encourage registry reporting, Congress could create a small, targeted incentive for clinicians to report to registries that meet rigorous criteria. The appropriate size of such an incentive merits further research, but a reasonable starting point would be 0.5 percent of clinicians' payments. The incentive could be structured as a budget-neutral combination of bonuses for compliance and penalties for non-compliance, similar to the existing payment adjustments under MIPS. Congress could consider applying this incentive to clinicians participating in Advanced APMs in addition to those participating in MIPS, as reporting by Advanced APM participants generates similar systemic benefits.

- *Eliminate the Promoting Interoperability category and create a targeted incentive for use of a certified EHR:* Encouraging clinicians to use EHRs that meet the certification standards promulgated by HHS generates substantial benefits for the health-care system by facilitating interoperability. It is much less clear, however, that there is a rationale for requiring providers to use these

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[26] Multi-specialty groups could be required to report on all measure sets that applied to more than a specified share of their clinicians.

[27] *Ibid.;* Medicare Payment Advisory Commission. 2018. "Moving Beyond the Merit-based Incentive Payment System." *http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch15_sec.pdf?sfvrsn=0.*

tools in particular ways, rather than allowing providers to use these tools in whatever way generates the greatest value for their patients.

For that reason, I recommend eliminating the MIPS Promoting Interoperability category and replacing it with a small, targeted incentive for having an EHR that meets the HHS certification standards. Practices could earn the incentive merely by showing that they have a suitable EHR installed and in active use, similar to the requirements currently in place for Advanced APMs. Clinicians would not be required to perform any specific activities with that EHR, unlike under MIPS. CMS has moved a significant distance in this direction in creating the requirements for the current Promoting Interoperability category, but it would be possible to at least modestly reduce burden by simplifying further. Like the incentive for registry reporting, the appropriate size of such an incentive merits further research, but a reasonable starting point would be 0.5 percent of clinicians' payments, structured as a budget-neutral combination of bonuses and penalties.

QUESTIONS SUBMITTED FOR THE RECORD TO MATTHEW FIEDLER, PH.D.

QUESTIONS SUBMITTED BY HON. ROB PORTMAN

Question. I introduced the Medicare Care Coordination Improvement Act with Senator Bennet in an effort to reduce some of the barriers that providers face when they participate in Alternative Payment Models. However, one particular section of my bill focuses on providing temporary waivers to practices that are interested in testing their own APMs. HHS has been slow to take up new APM concepts, and thus: what can we do to incentivize the establishment of new APMs? Has the PTAC offered a viable way to propose and test new APMs? If not, what actions could be taken to encourage the adoption of PTAC models?

Answer. In my view, focusing on expanding the portfolio of APMs clinicians can choose is a poor strategy for improving the quality and efficiency of Medicare beneficiaries' care. A proliferation of APMs would create opportunities for clinicians to choose among APMs based on which APM would be most financially advantageous to them, not which APM would generate the largest improvements in the quality and efficiency of patient care. This type of strategic APM selection could have various downsides, including increased costs for the Medicare program.

As discussed in my testimony, I do believe that expanding participation in Advanced APMs is an important objective. However, rather than achieving that objective by increasing the number of APMs clinicians can choose among, I would recommend: (1) increasing incentives for participation in existing Advanced APMs, notably accountable care organization models; and (2) testing and deploying additional episode and bundled payment models on a mandatory basis.

Question. Per data from CMS, about half of all Medicare providers are participating in MIPS, with the majority of these non-participating providers being exempt via the low-volume threshold. While we don't want to place additional burdens on small and rural providers, we should be identifying ways to engage with these practices to help them transition towards value-based outcomes.

What actions should be taken to engage with these providers?

Answer. Ensuring that all providers, including small and rural providers, deliver efficient, high-quality care is an important objective. However, due to the broader shortcomings of MIPS, which are discussed at length in my testimony, expanding these providers' engagement with MIPS is unlikely to pay major dividends. A more promising strategy for improving the quality and efficiency of patient care is to create stronger, more effective incentives to participate in Advanced APMs. As discussed in my response to the next question, while small and rural providers do face special barriers to engaging with such models, the existence of incentives to participate in Advanced APMs is spurring the private sector to develop approaches that make participating in these models feasible for many types of providers.

Question. I'd like to ask about your proposals to improve participation in APMs. I appreciate your proposal to "smooth out the cliff" for participating in APMs, but I want to get your perspective on whether this may be enough to incentivize small and rural practices to participate in APMs. Your proposal would help move providers towards APMs if they are already able to bear risk, but some of the smaller and rural practices may not be ready yet to do that.

What actions could Congress take to help these practices start to take on risk?

Answer. Small and rural providers face barriers to participation in Advanced APMs that other providers do not. However, even for these providers, I believe that strengthening and improving incentives for participation in Advanced APMs—including eliminating the cliff in the Advanced APM bonus eligibility rules and, more importantly, strengthening the overall size of the incentives for Advanced APM participation—is the best path to encouraging greater Advanced APM participation for all types of providers.

If strong, predictable incentives for Advanced APM participation are in place, I expect that the private sector will develop solutions that facilitate Advanced APM participation for all types of providers. Indeed, spurred in part by the existing incentives for Advanced APM participation, a range of private firms now offer services aimed at helping providers of all types participate successfully in Advanced APMs. These firms frequently take on a portion of the downside risk involved in participating in an Advanced APM and give providers tools designed to help them be successful under the APM, including analytic and programmatic support.

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. The Independence at Home demonstration, which was expanded and extended last year through the CHRONIC Care Act, enables care teams to deliver high-quality primary care to Medicare beneficiaries in the comfort of their own homes. In its third performance year, according to the Centers for Medicare and Medicaid Services (CMS), Independence at Home saved $16.3 million for the Medicare program.[1] A recent evaluation also found that Independence at Home has resulted in fewer emergency department visits leading to hospitalization, a lower proportion of beneficiaries with at least one unplanned hospital readmission during the year, and a reduced number of preventable hospital admissions.[2]

As I mentioned at the hearing, I am committed to building on the success of the Independence at Home demonstration. As discussed at the hearing, I understand that the new Primary Care First model recently announced by CMMI (the Center for Medicare and Medicaid Innovation at CMS) may provide an avenue to expand access to home-based primary care for more Medicare beneficiaries.

What key components will be necessary in order for the Primary Care First model to expand access to home-based primary care?

Answer. The performance-based payments available under the Primary Care First model are based primarily on providers' success in reducing hospitalizations. Thus, two things are likely to be required for the model to expand delivery of these services. First, providers must believe that home-based primary care services are a cost-effective means of reducing hospitalizations. Second, providers must be attentive to the financial incentives created under the model. Experience with CMMI's prior medical home models (the Comprehensive Primary Care Initiative and Comprehensive Primary Care Plus models) has been somewhat discouraging in this regard, but the payment methodology under the Primary Care First model is sufficiently different to merit additional testing.

Question. What other specific policies would you recommend Congress or CMS consider to expand access to home-based primary care for more Medicare beneficiaries?

Answer. In general, I would encourage Congress and CMS to focus on creating broad-based incentives for providers to improve the quality and efficiency of patient care. As discussed in my testimony, one promising way to do so would be to improve and strengthen incentives for providers to participate in Advanced APMs. This approach would reward greater provision of home-based primary care services in settings where those services are likely to improve the quality and efficiency of patient care, while ensuring that the Medicare program does not bear the cost if these services are deployed in settings where they are not appropriate or effective.

Question. As I mentioned during the hearing, I often hear from seniors in Oregon that they don't feel like anyone is in charge of managing their health care and helping them navigate the health-care system. I am proud of the bipartisan work that

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[1] *https://innovation.cms.gov/Files/fact-sheet/iah-yr3-fs.pdf.*
[2] *https://innovation.cms.gov/Files/reports/iah-rtc.pdf.*

this committee did on the CHRONIC Care Act last Congress to update the Medicare guarantee. In my view, the next step should be making sure that all Medicare beneficiaries with chronic illnesses have someone running point on their health care—in other words, a chronic care point guard—regardless of whether they get their care through Medicare Advantage (MA), an Accountable Care Organization (ACO) or other Alternative Payment Model, or traditional fee-for-service Medicare.

For beneficiaries in traditional, fee-for-service Medicare, what can be done to improve care coordination and make sure their physicians and other health-care professionals are all talking to each other and working together to provide the best possible care to those beneficiaries? What specific policies would you recommend this committee pursue toward that end?

Answer. Please see the response under the next question.

Question. Please describe the specific steps that Congress and/or CMS could take to ensure all Medicare beneficiaries with chronic illnesses, including those in traditional fee-for-service Medicare, have a chronic care point guard.

Answer. One worthwhile step would be to increase payments for evaluation and management services under the physician fee schedule, financed by a reduction in payments for other services. Such a step would likely expand the supply of primary care services and facilitate improvement in the quality of those services. This type of change would benefit all enrollees in traditional Medicare, including those cared for by providers not affiliated with an ACO. It might also benefit people covered by private insurers since Medicare's fee schedule frequently serves as a template for private insurers' payments.

However, there are likely limits to the improvements in care coordination that can be achieved in the context of fee-for-service payment models. Improving provider participation in ACOs and similar models is thus another important objective. As discussed in my testimony, one way to do so would be to improve and strengthen incentives for providers to participate in Advanced APMs.

QUESTION SUBMITTED BY HON. DEBBIE STABENOW

Question. I am very proud of the work the bipartisan accomplishments to address Alzheimer's, including the implementation of my HOPE for Alzheimer's Act which required Medicare to pay for new individual care plans to support Alzheimer's patients and their families. Many of my colleagues are also cosponsors of my Improving HOPE for Alzheimer's Act, which will ensure beneficiaries and physicians know that they are able to access, and bill for, care planning under Medicare. In our last hearing on MACRA implementation, my colleagues raised the question of how we should look at quality measures in MIPS when it comes to physicians having these conversations with beneficiaries and their families and reflecting their priorities. Some have mentioned altering MIPS to make the quality measures more clinically meaningful. In what ways do you think the system would need to change to better incorporate long-term care planning and encourage physicians to have these conversations with patients?

Answer. As I discussed in my testimony, in light of the discouraging results from research on pay-for-performance systems similar to MIPS, I am pessimistic that even a reformed MIPS program could produce substantial improvements in the quality of the care Medicare beneficiaries receive, including with respect to long-term care planning.

However, some improvement might be possible by standardizing the performance measures used in the MIPS quality category. As discussed in my testimony, clinicians' ability to choose the measures they are evaluated on under MIPS makes it difficult for CMS to use MIPS data to distinguish between high and low performers for payment purposes. It also makes it difficult for patients to use those data to choose a provider. These shortcomings, in turn, keep MIPS from creating strong incentives to improve quality performance. Standardizing the quality measures used under MIPS would give MIPS a fighting chance to improve care on the dimensions of quality that policymakers prioritized. Those could, if desired, include long-term care planning.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

THE PATIENT VOICE IN MACRA

Question. As I mentioned in my hearing questions, we passed MACRA to incentivize and reward high-value, patient-centered care. While MACRA is all about physician payment reform, our goal should be maximizing patient benefit. It is clear to me that we have not done enough to ensure the patient's voice is a part of the process, and that patients are benefitting from these changes. The NIH has created Patient-Focused Therapy Development tools and systems dedicated to engaging the patient community throughout the translational science process. The FDA has implemented a Patient-Focused Drug Development model to help ensure patients' experiences, perspectives, needs, and priorities are captured meaningfully during drug development and review.

Are you aware of any efforts to monitor MACRA's impact on patient satisfaction?

Answer. I am not aware of any ongoing research to estimate MACRA's effect on patient satisfaction.

Question. What is the best way to evaluate patient benefit across MACRA's programs?

Answer. Quantifying the effects of any policy intervention, including MACRA, requires determining what would have happened in the policy's absence. Researchers have a range of tools for doing this, but they are not universally applicable and must be carefully tailored to the particular setting in which they are applied. Thus, the best approach is likely to vary across MACRA's components, and it is not possible to identify a single best research design.

However, it is important that any comprehensive evaluation of MACRA's effects on Medicare beneficiaries account for the fact that these effects may be multifaceted. MACRA may affect "objective" measures of health status like longevity, as well as "subjective" measures of well-being like patient satisfaction. Reductions in the cost of care could also improve beneficiaries' financial security by reducing their premiums and cost-sharing. Obtaining a complete picture of MACRA's effects on Medicare beneficiaries requires taking account of—and appropriately weighing—all of these various effects.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Accountable Care Organizations (ACOs) have the potential to transform our health care delivery system. While we've seen ACOs improve patient care and create shared savings, many provider-led ACOs only control a small fraction of total spending, with specialists, pharmaceuticals, and hospitals accounting for most of it. This leads to ACOs lacking sufficient leverage to bring down costs and can contribute to shared losses.

How can we improve the ACO model to account for this imbalance? How can we support successful ACOs and encourage more providers to follow their lead?

Answer. Interestingly, the best research on the effect of the Medicare shared savings program has suggested that ACOs that do not include a hospital have had the greatest success in reducing Medicare spending.[3] Indeed, small ACOs may have one important advantage: unlike an ACO that includes a hospital, a physician-only ACO does not need to worry that reducing unnecessary hospitalizations will reduce its inpatient volume.

Nevertheless, the relatively small fraction of total spending accounted for by physician-led and, particularly, primary-care-led ACOs does present two special obstacles: (1) shared savings/shared losses calculated on the total cost of care can be large relative to these ACOs' revenue; and (2) these ACOs can have difficulty eliciting cooperation from other providers.

In my view, both problems can be ameliorated by improving the financial incentives for participation in Advanced APMs along the lines I recommended in my testimony. The first problem can be ameliorated by increasing the overall size of incentive for participation in Advanced APMs, which will make taking on significant fi-

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[3] McWilliams, J. Michael, Laura A. Hatfield, Bruce E. Landon, Pasha Hamed, and Michael E. Chernew. 2018 "Medicare Spending after 3 Years of the Medicare Shared Savings Program." *New England Journal of Medicine* 379(12): 1139–1149.

nancial risk to participate in such models more palatable for these types of providers.

The second problem can be addressed by creating incentives for non-physician providers to engage with Advanced APMs that parallel MACRA's incentives for physicians. For example, a hospital (or other category of provider) could receive an incentive payment based on the share of its volume received through ACOs with whom it had a formal collaboration agreement. Since the hospital would need the ACO's sign-off to receive the incentive payment, this would give the ACO leverage over the hospital's behavior that it lacks today.

It would be important to structure enhanced incentives for Advanced APM participation in ways that would not increase overall spending. That could be done by implementing a budget-neutral combination of bonuses for engaging with an Advanced APM and penalties for failing to do so, akin to how Congress combined bonuses and penalties under MIPS.

Question. Our health-care system is not fully equipped to care for an aging population and patients with advanced illness such as late-stage cancer, Alzheimer's disease or dementia, or congestive heart failure. This is an area where we need new models of care that reflect these challenges and create a better system for providers, patients, and their families. Many of our current Medicare rules in this space are counterproductive, such as requiring a 2-night, 3-day stay in an inpatient facility to qualify for skilled nursing care, and various disincentives to providing respite or palliative care. How are your organizations innovating to provide care for these patients, and what can Congress and CMS do to support those efforts?

Answer. Congress could facilitate the relaxation or removal of some of the Medicare rules you are concerned about by encouraging greater participation in Advanced APMs. Some of these rules, including the skilled nursing facility (SNF) 3-day rule, are motivated by concerns that providers have incentives to encourage inappropriate use of the relevant services in order to increase their Medicare payments. Those concerns largely do not exist when providers are at risk for a sufficient fraction of the cost of a beneficiary's care, as is the case under Advanced APMs. Because of this fact, CMS has issued partial waivers of the SNF 3-day rule for beneficiaries assigned to certain ACO models that involve two-sided risk. Broader participation in Advanced APMs would expand eligibility for these and similar waivers, as well as facilitate the creation of waivers in other similar areas.

Question. Despite continued investment, electronic health records (EHRs) remain difficult to share, challenging for patients to access, and a source of frustration to providers and policymakers alike. The business models of the EHR venders often leads to perverse incentives against sharing patient information.

What steps can Congress take to make EHRs work better for providers? Are the proposed data blocking rules enough to start encouraging better data sharing by the vendors?

Answer. I have not studied the EHR market carefully enough to make recommendations about how to improve EHR functionality. I have also not studied the proposed data blocking rules carefully enough to render a judgement. However, as I described in my testimony, there are opportunities to make Medicare's EHR requirements less burdensome for clinicians without compromising efforts to improve usability and interoperability. The MIPS promoting interoperability category could be replaced by a small payment incentive for having an EHR that meets Federal certification standards installed and in active use. Unlike under MIPS, clinicians would not be required to perform any specific activities with that EHR, which would limit compliance costs for providers. The incentive could be structured as a budget-neutral combination of payment bonuses and penalties.

Question. How can we encourage States to be better innovators on health-care spending? The current Medicaid waivers incentivize States to keep costs down, but are there ways to encourage both lower costs and better health-care outcomes?

Answer. Starting with Medicaid, because provider payment rates under State Medicaid programs are generally already relatively low, efforts to reduce the cost of delivering Medicaid coverage should focus on encouraging more efficient utilization of health-care services. Just like for the Federal Government, one promising strategy for States is to make greater use of non-fee-for-service payment mechanisms that reward efficient, high-quality care.

States are already engaged in a variety of efforts in this area (and frequently can do so without a waiver from CMS), but the Federal Government can support them

in a variety of ways. First, the Federal Government should continue its efforts to develop and deploy APMs. Federal payment reform efforts provide templates that other payers, including State Medicaid programs, can use in their own payment reform efforts. Second, where possible, the Federal Government should partner with State Medicaid programs to deploy APMs that are harmonized across Medicare, Medicaid, and private payers. CMS has already done this in some instances, but it should look for additional opportunities to do so in the future.

Looking beyond Medicaid, States should also seek to reduce the cost of health care in the private insurance market. In particular, States should seek to foster robust competition in health care provider markets and health insurance markets. That could include robustly enforcing antitrust laws with respect to mergers and anti-competitive conduct, as well as repealing State laws that inhibit competition, such as so-called "any willing provider" laws. The Federal Government could encourage activities like these by providing grant funding to States that act in these areas. The Federal Government should also remove barriers that keep States from getting a comprehensive picture of their health-care markets; notably, Congress should address limitations on States' ability to construct all-payer claims databases that were created by the Supreme Court's decision in *Gobeille vs. Liberty Mutual Insurance Company*.

QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO

Question. Early on, with Meaningful Use, Congress heard a lot from providers about the complexity and reporting burden; we are hearing less but concerns remain.

Should the EHR vendors be responsible for ensuring use and workability rather than the doctors? How would that work?

Answer. As I discussed in my testimony, there are opportunities to make Medicare's EHR requirements less burdensome for clinicians. In particular, the MIPS promoting interoperability category could be replaced with a small payment incentive for having an EHR that meets Federal certification requirements installed and in active use. Unlike under MIPS, clinicians would not be required to perform any specific activities with that EHR, which would limit clinicians' compliance burdens. The incentive could be structured as a budget-neutral combination of payment bonuses and penalties.

It is important, however, to retain some direct incentive for providers to install and use certified EHRs since the Federal certification standards are an important tool for promoting interoperability. While vendors could be encouraged to market EHRs that meet these standards using other policy tools, some incentive for providers is likely necessary to ensure that providers actually adopt those EHRs.

Question. How do we bring the rest of the health-care workforce online—ambulances, mental health providers, etc.?

Answer. As with physicians and hospitals, encouraging other types of providers to use EHRs that meet Federal certification standards has the potential to benefit the health-care system as a whole by facilitating interoperability. Creating a modest payment incentive for having a certified EHR installed and in active use, similar to the incentive my testimony proposes for clinicians, would be one approach to this problem worth considering.

PREPARED STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

I want to thank the witnesses for being here today. We look forward to hearing how physician payment reforms in the Medicare Access and CHIP Reauthorization Act are driving good patient outcomes. The MACRA law also took the historic step of getting rid of the flawed sustainable growth rate formula.

Let me take a moment to go through the history of the SGR as the saga ended with a hopeful message. Congress established the SGR in 1997 as a mechanism to control Medicare spending on physician services. The formula worked at first, but it wasn't long before it called for large reductions in payments that threatened access to care. This set in motion a perpetual exercise where Congress scrambled to prevent the cuts.

Congress acted 17 times over more than a decade—each time kicking the can down the road without solving the underlying problem. Then, in 2015, Congress finally came together and passed the MACRA law by an overwhelming margin in both chambers. MACRA showed that Congress can still work together in a bipartisan manner to address big problems.

This reminder reinforces my belief in the current bipartisan Finance Committee process to lower prescription drug costs. It bodes well for making changes in Medicare to improve access to care for patients in rural and underserved areas. This is another project to which Ranking Member Wyden and I are committed.

These bipartisan efforts also provide a glimmer of hope that Republicans and Democrats can join together to prevent Medicare from going broke. I urge my colleagues on the other side of the aisle to focus on shoring up Medicare's finances. This is time better spent than trying to expand Medicare for all only for it to invariably end up available to none.

The MACRA payment reforms established incentives for physicians to provide the highest quality of care at the lowest possible cost. Physicians can pick from two different paths. They can opt to be graded on metrics in a number of different categories, or choose to get paid under a different model, such as a single payment for a bundle of services.

This committee held a hearing in 2016 on the initial plan by the Centers for Medicare and Medicaid Services to implement these reforms. While the CMS implementation remains a work-in-progress, the 2 years of experience allow us to take stock of how well these reforms are working. That's why we brought in physicians and other experts who are at the forefront of these efforts.

The witnesses are from physician organizations that represent different specialties and practice characteristics. This diversity of physician practice mirrors the varying needs of Medicare patients. It also highlights the inherent challenge in getting top-notch care to everyone, including those in rural areas.

I am proud that physicians in Iowa provide high-quality care while spending less than in many other areas. This is the value that the MACRA payment reforms aim to achieve.

I look forward to hearing from the witnesses about their experience and what Congress should consider for the road ahead.

PREPARED STATEMENT OF SCOTT HINES, M.D., DIRECTOR,
AMERICAN MEDICAL GROUP ASSOCIATION

Chairman Grassley, Ranking Member Wyden, and distinguished members of the Senate Finance Committee, thank you for the opportunity to testify on behalf of AMGA, where I serve as chair of its Public Policy Committee and member of their board of directors. AMGA represents 450 multispecialty medical groups and integrated delivery systems across the United States. More than 175,000 physicians practice in AMGA member organizations, delivering care to one in three Americans.

I am board-certified in internal medicine, endocrinology, diabetes, and metabolism, and am Crystal Run Healthcare's chief quality officer, as well as medical director and physician leader for our medical specialties division. Crystal Run Healthcare employs more than 450 providers across 50 different primary care, medical, and surgical specialties in 20 locations throughout the lower Hudson Valley of New York State. We were among the first 27 Accountable Care Organizations (ACOs) to participate in the Medicare Shared Savings Program (MSSP) since 2012. In my role as chief quality officer, I have helped develop and implement the clinical programs necessary to deliver value-based care to our patients.

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

The Centers for Medicare and Medicaid Services (CMS) envisioned that MACRA would help achieve three goals for the health-care system—better care, smarter

spending, and healthier people. The law and regulations would achieve this by rewarding physicians who performed well in three key areas: payment incentives, care delivery, and information sharing.

Policymakers in Congress and the administration have made clear their intent to transform the way health care is financed and delivered in this country. The need to move Medicare to value is evident today, more than ever, and I believe Congress passed MACRA to drive that transition to value in Medicare Part B. Our current fee-for-service payment system is not sustainable and is not the model best suited to provide coordinated, high quality, cost effective care to our patients. AMGA members are looking to Congress for a stable, predictable value program that creates meaningful and realistic incentives that motivates them to make the multimillion-dollar investments needed to chart a course to value.

Congressional passage of MACRA aimed to bring more stability to Medicare physician reimbursement by granting providers predictable payments until this year, when two new systems would be fully implemented: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). AMGA members, like Crystal Run Healthcare, have invested considerable time and resources to deliver the best possible care while embarking on this pathway to value, and have concerns with the implementation of these two systems.

WHAT IT TAKES TO DELIVER VALUE-BASED CARE

The competencies necessary to deliver coordinated, value-based care are not incentivized in a fee-for-service system. Over the past decade, Crystal Run Healthcare has invested tens of millions of dollars in the infrastructure, personnel, and technology needed to deliver care that improves quality and lowers cost. Crystal Run care managers, for example, act as liaisons and points of contact between visits to ensure that our patients understand and comply with their personalized care plans. Our technology solutions risk stratify the population to identify the most vulnerable patients under our care. Homegrown analyses evaluate variations in care to increase awareness of, and adherence to, evidence-based practice guidelines. A Care Optimization Team reaches out to patients identified to have gaps in care in an effort to reengage them and get them the care that they need. None of this is rewarded in a transactional, fee-for-service system. Provider groups like Crystal Run rely on dependable, value-oriented payment models from CMS in order to continue to provide such services.

These services have a direct, positive impact on our patients. In the MSSP program in 2017, which is the most recent year for which we have finalized data, we reduced inpatient admissions per 1,000 patients by 3.4 percent when compared to 2016. We reduced our readmission rate from 16.3 percent to 14.25 percent, we reduced our emergency room (ER) utilization by 4.9 percent, and we reduced our per member per month spend on skilled nursing facilities by 9 percent. In total, we saved CMS $5.6 million on the nearly 15,000 beneficiaries we were accountable for that year. As significant as this may be on a population level, it is more impactful to understand how care is different, and better, on an individual patient level.

Take patient A as an example. Patient A is a Medicare beneficiary in the MSSP program who was referred to the endocrinology clinic for uncontrolled diabetes. During the history and examination it was discovered that her blood sugar was four times normal and she was significantly dehydrated. Intravenous fluids and subcutaneous insulin were administered immediately in the clinic and the patient started to feel better. Upon further questioning, she said that she had not been exercising of late due to developing chest tightness and shortness of breath whenever she walked up an incline. A cardiology consult was immediately sought and the patient was transported across the hall to the cardiology clinic. There she had an EKG and echocardiogram that suggested she had unstable angina. An interventional cardiologist was called and advised his colleague to send Patient A to the local ER where he would admit her for a cardiac catheterization. That study revealed two blockages that were able to be stented and the patient was admitted for observation and discharged the next day. The series of events from office visit to catheterization occurred over the course of less than twelve hours because care was coordinated and provided in a multispecialty setting.

Contrast Patient A with one of my relatives (Patient B) who obtains his medical care in a typical community setting. Patient B called his primary care physician complaining of worsening back pain. He was told to go to the ER because he had no open appointments that day. Upon arrival in the ER, he was given one dose of intravenous pain medication and waited 4 hours to see a physician. That physician

did a cursory examination and told Patient B that he needed to make a follow-up with the on call orthopedic surgeon. The first available appointment was in 2 weeks. At that appointment, the nurse told Patient B that the surgeon he was scheduled to see was a shoulder specialist, not a back specialist so he needed to reschedule his appointment since the back surgeon was not in the office that day. Two weeks later, Patient B finally saw the back specialist and was told that he needed surgery pending medical clearance. Since Patient B's primary care physician and cardiologist were in different practices from the orthopedic surgeon, it took nearly 6 weeks to obtain the necessary clearance for surgery. Luckily, the surgery went smoothly but Patient B was forced to remain in the hospital an extra day because there was confusion on who was supposed to discharge him. That extra time in the hospital resulted in a urinary tract infection that worsened Patient B's dementia and required an additional two days in the hospital and a brief stay in a skilled nursing facility (SNF) after discharge. Given the experiences of Patient A and Patient B, in which setting would you like your children or parents to receive care?

MERIT-BASED INCENTIVE PAYMENT SYSTEM

MIPS was designed as a transition tool—an on-ramp to value-based payment in the Medicare program. However, CMS has not implemented MIPS as Congress intended. Under MACRA, MIPS providers would have the opportunity to earn positive or negative payment adjustments based on their performance, starting at +/-4 percent in 2019 and increasing to +/-9 percent in 2023. By putting provider reimbursements at risk, Congress intended to move Medicare to a value-based payment model where high performance was rewarded and poor performers were incentivized to improve with lower payment rates.

Despite Congress's goals, CMS has excluded nearly half of eligible clinicians from MIPS requirements through its MACRA regulations. Because MIPS is budget neutral, these exclusions result in insignificant payment adjustments to high-performing providers. For example, in 2020, CMS expects a 1.5-percent payment adjustment for high performers, compared to a potential 5-percent adjustment provided for in the law. And in 2021, CMS expects a 2-percent payment adjustment for high performers, but the statute allows for a potential 7-percent adjustment. By excluding half of providers from MIPS, the system has devolved into an expensive regulatory compliance exercise with little impact on quality or cost.

I understand my colleagues' concerns for physicians practicing in solo or smaller practices, and that the reporting burden on them is at times significant. However, we must recall that the MIPS program is a continuation of quality programs that have existed for years, namely the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBM), and the Meaningful Use (MU) programs, where previously no one was excluded from participating—especially not half of eligible clinicians. In fact, under prior law, combined penalties for failure to participate in PQRS, VBM, and MU could be up to negative 11 percent.[1] Additionally, there is an opportunity for bonus points for high performers under MIPS.

Congress correctly anticipated that small and rural providers may need extra assistance and authorized funding in MACRA to provide that help. With this funding CMS created the Small, Underserved, and Rural Support initiative to provide free, customized technical assistance to clinicians in small practices. This serves both the small clinicians and the overall Medicare program better than simply excusing them from participation. If we want to be successful in moving our health-care system to value, policymakers should no longer exclude providers from participating in MIPS.

ADVANCED ALTERNATIVE PAYMENT MODEL PROGRAM

For Advanced APMs, the other pathway to value under MACRA, the system's requirements need to be revised to allow for increased APM participation. To qualify for the program, providers must meet or exceed minimum revenue thresholds from APMs, or minimum numbers of Medicare beneficiaries in these models. For example, for performance year 2019, in order to become a qualified participant, a provider must receive at least 50 percent of their Medicare Part B payments, or see at least 35 percent of Medicare patients through Advanced APMs. The threshold increases to 75 percent of revenue for performance year 2021. However, AMGA members re-

[1] Statement of the American Medical Association to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health, Re: "MACRA and MIPS: An Update on the Merit-based Incentive Payment System," July 26, 2018, *https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Testimony-Barbe-%20HE-MACRA-and-MIPS-An-Update-on-the-Merit-based-Incentive-Payment-System-2018-07-26.pdf.*

port APM requirements are unrealistic, unlikely to be met, and will not attract the numbers of physicians and medical groups necessary to ensure the program's success.

In order for more providers to transition to value, there is a need for Congress to offer meaningful incentives so providers will make the multimillion-dollar investments to build a value-based platform. By eliminating or revising these arbitrary thresholds, and extending the APM program beyond its 2024 sunset date, Congress would strongly demonstrate to the health-care community its commitment to offering a stable and predictable risk platform to providers ready to move to value.

Accountable Care Organizations

Participants in the Federal ACO program, like Crystal Run Healthcare, have been moving towards value while making improvements in care processes and the delivery of high-quality care, all while reducing healthcare utilization. However, ACOs have encountered significant obstacles in program design that threaten not only their own success, but also the future sustainability of the program. AMGA members have invested considerable financial, clinical, operational, and leadership resources to establish sophisticated care management infrastructures and organizational cultures necessary to support the goals of the ACO program. ACOs need a workable financing and operational structure that adequately incentivizes their move to value. In order to maintain the viability and structure of the ACO program, AMGA has several recommendations.

Providers that willingly assume financial risk for a patient population require a consistent regulatory framework. In the ACO program, rules that shift depending on what level of risk is accepted is counterproductive, as the care delivery processes must change to adapt to new program rules. Lessons learned under one set of rules may not apply to a care process that must account for a different set of requirements or options. For example, rather than use payment waivers or beneficiary incentive programs as an incentive to take on risk, Congress should synchronize rules across all Federal ACO levels. This will allow providers who participate in the program to create delivery models that incorporate payment waivers such as the 3-day qualifying inpatient stay for SNF care and other post-discharge home-visit supervision requirements. Limiting these waivers or any beneficiary incentives to a subset of ACOs creates a situation that requires providers to adjust how they deliver care with no benefit to patients. Indeed, why patients should be required to stay in a hospital for three days or more before they are discharged to a SNF penalizes the patient for no other reason than a provider is in a different ACO level than another. The only meaningful difference in ACOs should be the level of financial risk a provider is willing to accept as an ACO moves up the risk continuum.

Appropriate and accurate risk adjustment is a vital aspect of any performance-based program. When determining the risk adjustment factor, CMS has become overly concerned about coding efforts. Instead, the risk adjustment methodology should be chiefly concerned with the health status of the population assigned to the ACO. CMS uses Hierarchical Condition Category (HCC) prospective risk scores to account for changes in severity and case mix. It is possible that year-over-year the population's health status may improve. Conversely, it may worsen. As such, a risk adjustment factor should be concerned with just that: the health status of the ACO's beneficiaries.

CMS's recent decision to set a 40-percent shared savings rate for ACO Basic Levels A and B only weakens financial incentives to move providers to risk. This level is insufficient and less than what was originally included in the MSSP. The levels of shared savings need to be increased to encourage participation and recognize the investments ACOs make.

We should adjust ACO regional benchmarking so that they are not competing against themselves. Currently, CMS incorporates historical spending when resetting subsequent agreement period benchmarks. Historical spending should factor into a reset benchmark for those ACOs that are spending more than their region. These ACOs will then have the incentive to address their spending and align their costs to that of their region. However, those ACOs that have demonstrated an ability to deliver care below the regional cost should be evaluated against their region, as it would be increasingly difficult for an ACO to consistently perform better than its historical costs.

Lastly, new repayment mechanisms should be provided for ACOs. As of 2015, CMS no longer allows ACOs to purchase reinsurance policies as a repayment mech-

anism. Allowing for ACOs in two-sided risk-based contracts to purchase a reinsurance policy would allow them to mitigate significant financial losses.

I truly believe Congress passed MACRA to drive the transition to value in Medicare Part B. However, since 2017, the first performance year for MIPS, we have clearly taken a step back from this transition, by excluding half of eligible clinicians from MIPS and enforcing arbitrary threshold requirements for Advanced APMs. Additionally, providers in the MSSP need one, and only one set of rules to follow. Creating different programmatic rules depending on which track a provide is on requires ACOs to develop new care processes based not on what is best for the patient, but rather by what CMS requires. On behalf of AMGA and Crystal Run Healthcare, we are ready to work with Congress and CMS to ensure that MACRA can serve its intended purpose in moving our Medicare system to value.

QUESTIONS SUBMITTED FOR THE RECORD TO SCOTT HINES, M.D.

QUESTIONS SUBMITTED BY HON. ROB PORTMAN

Question. I introduced the Medicare Care Coordination Improvement Act with Senator Bennet in an effort to reduce some of the barriers that providers face when they participate in alternative payment models. However, one particular section of my bill focuses on providing temporary waivers to practices that are interested in testing their own APMs. HHS has been slow to take up new APM concepts, and thus: what can we do to incentivize the establishment of new APMs? Has the PTAC offered a viable way to propose and test new APMs? If not, what actions could be taken to encourage the adoption of PTAC models?

Answer. In order to establish new APMs, Congress must offer meaningful incentives so providers will make the multimillion-dollar investments to build a value-based platform. By eliminating or revising the arbitrary thresholds, and extending the APM program beyond its 2024 sunset date, Congress would strongly demonstrate to the health-care community its commitment to offering a stable and predictable risk platform to providers ready to move to value. Synchronizing rules across all APMs would also incentivize their establishment.

Current APM participants, like those in the Federal Accountable Care Organization (ACO) program, have made significant improvements in care processes and the delivery of high-quality care, while reducing health-care utilization. Although many ACOs have improved the quality of care and saved Medicare dollars, program results have been uneven at best. ACOs have encountered significant obstacles in program design that threaten not only their own success, but also the future viability of this program.

AMGA members have invested significant financial, clinical, operational, and leadership resources to establish sophisticated care management infrastructures and organizational cultures necessary to support the goals of the ACO program. They have done so because it is the right thing to do for their patients and they want to assist Congress, the Centers for Medicare and Medicaid Services (CMS), and other payers to create the new payment models that reward coordinated, patient-centered care with measurable outcome improvements. To achieve that goal, ACOs need a workable financing and operational structure that adequately incentivizes this important work.

Question. Per data from CMS, about half of all Medicare providers are participating in MIPS, with the majority of these non-participating providers being exempt via the low-volume threshold. While we don't want to place additional burdens on small and rural providers, we should be identifying ways to engage with these practices to help them transition towards value-based outcomes.

What actions should be taken to engage with these providers?

Answer. We understand the concerns for physicians practicing in rural or small practices that the reporting burden on them is at times significant. However, the MIPS program is a continuation of quality programs that have existed for years, namely the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBM), and the Meaningful Use (MU) programs, where previously no one was excluded from participating—especially not half of eligible clinicians. In fact, under prior law, combined penalties for failure to participate in PQRS, VBM, and MU could be up to negative 11 percent. In addition to these legacy quality programs that have been around for 10 years, when MACRA passed in 2015 it gave doctors

4 years of 0.5 percent automatic updates to get ready to participate. There is also an opportunity for bonus points for high performers under MIPS.

Congress correctly anticipated that small and rural providers may need extra assistance and authorized funding in MACRA to provide that help. With this funding, CMS created the Small, Underserved, and Rural Support initiative to provide free, customized technical assistance to clinicians in small practices. This serves both the small clinicians and the overall Medicare program better than simply excusing them from participation. MACRA should be implemented as the statute requires and policymakers should no longer exclude providers from participating in MIPS.

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. The Independence at Home demonstration, which was expanded and extended last year through the CHRONIC Care Act, enables care teams to deliver high-quality primary care to Medicare beneficiaries in the comfort of their own homes. In its third performance year, according to the Centers for Medicare and Medicaid Services (CMS), Independence at Home saved $16.3 million for the Medicare program.[1] A recent evaluation also found that Independence at Home has resulted in fewer emergency department visits leading to hospitalization, a lower proportion of beneficiaries with at least one unplanned hospital readmission during the year, and a reduced number of preventable hospital admissions.[2]

As I mentioned at the hearing, I am committed to building on the success of the Independence at Home demonstration. As discussed at the hearing, I understand that the new Primary Care First model recently announced by CMMI (the Center for Medicare and Medicaid Innovation at CMS) may provide an avenue to expand access to home-based primary care for more Medicare beneficiaries.

Based on your members' experience in Independence at Home and other alternative payment models, what key components will be necessary in order for the Primary Care First model to expand access to home-based primary care?

Answer. We are looking forward to reviewing the details of the Primary Care First model when the Centers for Medicare and Medicaid Services issues its Request for Applications later this year. In any value-based model of care, however, there are some key features that providers will need to have the best opportunity to succeed. In order for the Primary Care First model to expand access to home-based primary care, incentives for providers must exist. I also would recommend that Congress eliminate the arbitrary APM threshold requirements so that more providers will qualify as an Advanced Alternative Payment Model under the Quality Payment Program. In addition, the APM program should be extended beyond 2024.

Lack of access to administrative claims data also is a barrier to the success of these payment models. AMGA members report that while some payers share this data with them, the majority of payers do not. Without this data, it is challenging to manage the cost and quality of a population of patients, which is a goal of moving to value-based care. Congress should require Federal and commercial payers to provide accurate, timely access to all administrative claims data to health-care providers in value-based arrangements.

Question. What other specific policies would you recommend Congress or CMS consider to expand access to home-based primary care for more Medicare beneficiaries?

Answer. Additionally, we recommend Congress or CMS consider expanding telehealth, eliminating the 20 percent Chronic Care Management cost-sharing requirement, and decreasing administrative burden and providing regulatory relief for participants in these models.

Question. As I mentioned during the hearing, I often hear from seniors in Oregon that they don't feel like anyone is in charge of managing their health care and helping them navigate the health-care system. I am proud of the bipartisan work that this committee did on the CHRONIC Care Act last Congress to update the Medicare guarantee. In my view, the next step should be making sure that all Medicare beneficiaries with chronic illnesses have someone running point on their health care—in other words, a chronic care point guard—regardless of whether they get their

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[1] *https://innovation.cms.gov/Files/fact-sheet/iah-yr3-fs.pdf.*
[2] *https://innovation.cms.gov/Files/reports/iah-rtc.pdf.*

care through Medicare Advantage (MA), an accountable care organization (ACO) or other alternative payment model, or traditional fee-for-service Medicare.

For beneficiaries in traditional, fee-for-service Medicare, what can be done to improve care coordination and make sure their physicians and other health-care professionals are all talking to each other and working together to provide the best possible care to those beneficiaries? What specific policies would you recommend this committee pursue toward that end?

Answer. To improve care coordination, we recommend continued efforts by Congress to reduce Medicare's regulatory burden by linking regulatory reform efforts to providers participating in value-based payment models. For example, Federal legislation and regulations governing physician self-referral, collectively termed the "Stark Law," were intended to prevent financial conflicts of interest around physician self-referrals in fee-for-service (FFS) settings. As Medicare transitions to value-based arrangements, the need for these protections and related self-referral and anti-kickback regulations lessen, as incentives to over-utilize health-care services diminish.

Participants in the MSSP or ACO program often have to receive several fraud and abuse waivers since the financial incentives push providers to improve the continuity, coordination, and continuum of care for assigned ACO beneficiaries. The Stark Law's prohibitions, which were drafted 30 years ago, impede the physician-hospital relationships necessary to address overuse of services. The Stark Law was drafted to address volume of service increases in FFS Medicare. It has virtually no application in value models, which incentivize appropriate use of services. This law should be updated to account for changes in care models that have led to more integrated care delivery.

Question. Please describe the specific steps that Congress and/or CMS could take to ensure all Medicare beneficiaries with chronic illnesses, including those in traditional fee-for-service Medicare, have a chronic care point guard.

Answer. The recent legislation to waive the cost-sharing requirements of Medicare's Chronic Care Management (CCM) code is a great example of putting the idea of a chronic care point guard into practice. CCM is a critical part of coordinated care, and as a result, Medicare began reimbursing physicians for CCM under a separate code in the Medicare Physician Fee Schedule. As you are aware, this code is designed to reimburse providers for non-face-to-face care management. We support this initiative to further manage chronic care conditions to improve the health of patients.

The creation of a separately billable code, however, created a beneficiary cost-sharing obligation for care management services. Under current policy, Medicare beneficiaries are subject to a 20 percent coinsurance requirement to receive the service. This cost-sharing requirement creates a barrier to care, as beneficiaries are not accustomed to sharing the cost for care management services. Consequently, only 684,000 out of 35 million Medicare beneficiaries with two or more chronic conditions benefited from CCM services over the first 2 years of the payment policy.

AMGA supports the legislation to waive the beneficiary coinsurance amount to facilitate further appropriate management of chronic care conditions to improve the health of patients. Providers and care managers, who would fulfill the role of the chronic care point guard, report many positive outcomes for beneficiaries who receive CCM services, including improved patient satisfaction and adherence to recommended therapies, improved clinician efficiency, and decreased hospitalizations and emergency department visits.

Question. Eligible clinicians who receive a certain percentage of their payments or see a certain percentage of their patients through Advanced APMs are excluded from MIPS and qualify for the 5 percent incentive payment for payment years 2019 through 2024. Starting this year (performance year 2019), eligible clinicians may also become qualifying APM participants (and thus qualify for incentive payments in 2021) based in part on participation in Other Payer Advanced APMs developed by non-Medicare payers, such as private insurers, including Medicare Advantage plans, or State Medicaid programs.

Recognizing that this is the first year in which the All-Payer Combination Option is available, how many of your members do you anticipate will take advantage of the All-Payer Combination Option this year?

Answer. We do not have the data available to answer at this time but we would expect that very few of our members are able to take advantage of this because,

based on our risk surveys, commercial payers are not offering an adequate amount of risk based contracts in many markets.

Question. What, if any, challenges have your members faced when attempting to take advantage of the All-Payer Combination Option?

Answer. Not applicable.

Question. In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress provided a total of $100 million over 5 years for technical assistance to MIPS-eligible clinicians in practices with 15 or fewer clinicians, focusing on rural and health professional shortage areas.

To what extent have your members utilized the services of the Small, Underserved, and Rural Support Initiative, which CMS launched using the MACRA funding to provide free, customized technical assistance to clinicians in small practices?

Answer. AMGA members have been preparing for the transition to value so we did not require additional assistance from the government to follow the MACRA statute.

Question. What types of technical assistance and support have been most helpful to physicians and practices (*e.g.,* understanding program requirements, selecting appropriate measures, forming virtual groups)?

Answer. Not applicable.

Question. As physicians continue to gain experience with the Quality Payment Program, what additional types of technical assistance would be most helpful to solo practitioners and physicians in small practices and/or to those practicing medicine in rural or underserved areas?

Answer. Additional technical assistance that would be helpful to solo practitioners and physicians in small practices or rural areas would be incentives to report quality measures while participating in the MIPS program.

QUESTIONS SUBMITTED BY HON. DEBBIE STABENOW

Question. You mentioned the Small, Underserved, and Rural Support Initiative in your testimony. What have you heard from your members and colleagues about the effectiveness of this funding for assisting rural practices, and how do you think it could be improved?

Answer. Not applicable.

Question. I am very proud of the work the bipartisan accomplishments to address Alzheimer's, including the implementation of my HOPE for Alzheimer's Act which required Medicare to pay for new individual care plans to support Alzheimer's patients and their families. Many of my colleagues are also cosponsors of my Improving HOPE for Alzheimer's Act, which will ensure beneficiaries and physicians know that they are able to access, and bill for, care planning under Medicare. In our last hearing on MACRA implementation, my colleagues raised the question of how we should look at quality measures in MIPS when it comes to physicians having these conversations with beneficiaries and their families and reflecting their priorities. Some have mentioned altering MIPS to make the quality measures more clinically meaningful. In what ways do you think the system would need to change to better incorporate long-term care planning and encourage physicians to have these conversations with patients?

Answer. To begin, over 50 percent of eligible clinicians should not be excluded from participation in MIPS. For the quality measures to truly be more clinically meaningful, patients must receive care from providers that actually report these measures.

In addition, AMGA has endorsed a set of value measures designed to simplify the reporting process and limit the burden on providers and group practices, while still reporting clinically relevant and actionable data. The 14 measures were selected to address the flaws with the current quality measurement and reporting system, which suffers from duplicative measures and a lack of data standardization. AMGA believes that the use of this set of core measures will ultimately save providers' time and reduce costs while improving care.

The 14 measures are:

1. Emergency Department use per 1,000.
2. SNF admissions per 1,000.
3. 30-day all cause hospital readmission.
4. Admissions for acute ambulatory sensitive conditions composite.
5. HbA1C poor control > 9 percent.
6. Depression screening.
7. Diabetes eye exam.
8. Hypertension (HTN)/high blood pressure control.
9. CAHPS/health status/functional status.
10. Breast cancer screening.
11. Colorectal cancer screening.
12. Cervical cancer screening.
13. Pneumonia vaccination rate.
14. Pediatric well child visits (0–15 months).

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

THE PATIENT VOICE IN MACRA

Question. As I mentioned in my hearing questions, we passed MACRA to incentivize and reward high-value, patient-centered care. While MACRA is all about physician payment reform, our goal should be maximizing patient benefit. It is clear to me that we have not done enough to ensure the patient's voice is a part of the process, and that patients are benefiting from these changes. The NIH has created Patient-Focused Therapy Development tools and systems dedicated to engaging the patient community throughout the translational science process. The FDA has implemented a Patient-Focused Drug Development model to help ensure patients' experiences, perspectives, needs, and priorities are captured meaningfully during drug development and review.

In your testimony, you shared the story of a relative who got caught in the healthcare system's inefficiencies. Unfortunately, I hear similar stories from Ohioans far too often. What more can and should we do to ensure both MIPS and APM programs prioritize and value patient satisfaction?

Answer. MACRA must be allowed the chance to work by being implemented as originally intended. You will never move the needle towards a value-based healthcare system that values patient satisfaction when half of eligible clinicians are excluded from participation in MIPS. The APM system's requirements need to be revised to allow for increased APM participation as well, such as eliminating the arbitrary threshold requirements.

DEVELOPMENT OF METRICS IN MACRA

Question. I have heard from a number of physicians who believe that there is no link between many of the MIPS measures they are required to report and improving clinical care for their patients. I understand that the physician community has engaged with CMS to try and make the program more meaningful to physicians and patients through more relevant quality measures.

How are clinicians from your organization involved the creation of these measures relevant to their specialties?

Has CMS been receptive to your feedback when provided?

How would you assess CMS's collaboration on achieving meaningful metrics?

Are there any changes in this process you would recommend?

Answer. We are encouraged by CMS's efforts with the meaningful measures initiative. To help with this effort, AMGA endorsed a set of value measures designed to simplify the reporting process and limit the burden on providers and group practices, while still reporting clinically relevant and actionable data.

The 14 measures were selected to address the flaws with the current quality measurement and reporting system, which suffers from duplicative measures and a lack of data standardization. AMGA members report hundreds of different quality measures to various public and private payers, the vast majority of which are not useful in evaluating or improving the quality of care provided. There is a significant cost to measure reporting. Research has indicated that, on average, U.S. physician practices across four common specialties annually spend more than $15.4 billion and 785 hours per physician to report quality measures.

AMGA believes that the use of this set of 14 core measures will ultimately save providers' time and reduce costs while improving care. By offering a standard set of measures for value-based contracts with payers, the AMGA measure set will reduce the variation in the measures that are reported and help eliminate unnecessary confusion and administrative burden. The measurement set includes both process measures, such as cancer screening and immunization rates, which focus attention on quality improvement, and outcome measures, which emphasize the need to evaluate how care is provided to best drive quality improvement.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Accountable Care Organizations (ACOs) have the potential to transform our health care delivery system. While we've seen ACOs improve patient care and create shared savings, many provider-led ACOs only control a small fraction of total spending, with specialists, pharmaceuticals, and hospitals accounting for most of it. This leads to ACOs lacking sufficient leverage to bring down costs and can contribute to shared losses.

How can we improve the ACO model to account for this imbalance? How can we support successful ACOs and encourage more providers to follow their lead?

Answer. In order to improve the ACO model and support successful ACOs, AMGA recommends the following: synchronize rules across all Federal ACO levels; reduce regulatory burdens on ACOs; increase the Shared Savings Rate to incentivize participation in the program; adjust MSSP ACO regional benchmarking so that they are not competing against themselves; and provide for new repayment mechanisms for ACOs.

Question. Our health-care system is not fully equipped to care for an aging population and patients with advanced illness such as late-stage cancer, Alzheimer's disease or dementia, or congestive heart failure. This is an area where we need new models of care that reflect these challenges and create a better system for providers, patients, and their families. Many of our current Medicare rules in this space are counterproductive, such as requiring a two night, three-day stay in an inpatient facility to qualify for skilled nursing care, and various disincentives to providing respite or palliative care. How are your organizations innovating to provide care for these patients, and what can Congress and CMS do to support those efforts?

Answer. Policy-makers should waive the 3-day qualifying inpatient stay for skilled nursing facility (SNF) care and implement policies that encourage providers to work with their patients to provide services in the most clinically appropriate location.

The Social Security Act requires Medicare beneficiaries to have an inpatient hospital stay of no fewer than 3 consecutive days to be eligible for Medicare coverage of SNF care. This rule dates back to the inception of the Medicare program, and is referred to simply as the SNF 3-Day Rule. The 3-day stay is not required for other forms of post-acute care, including home health care or inpatient rehabilitation facility stays. Today, under pay-for-value arrangements, the 3-Day Rule has become, as the Medicare Payment Advisory Commission (MedPAC) previously noted, "antiquated."

Question. Despite continued investment, electronic health records (EHRs) remain difficult to share, challenging for patients to access, and a source of frustration to providers and policymakers alike. The business models of the EHR venders often leads to perverse incentives against sharing patient information.

What steps can Congress take to make EHRs work better for providers? Are the proposed data blocking rules enough to start encouraging better data sharing by the vendors?

Answer. In our May 2016 principles for interoperability, AMGA stressed the need to help providers share a patient's health information between each other and the patient and not block the exchange of electronic health information. As we strive for a health-care system that rewards value over volume, the need to ensure this information is freely exchanged becomes even more important. Information-blocking practices are contrary to a desired well-coordinated healthcare delivery system because sharing information seamlessly across the care continuum is fundamental to moving toward a patient-centered, high-performing delivery system. As such, the exceptions to the information-blocking provisions outlined in the recent ONC interoperability proposed rule are adequate and no additional exceptions are warranted.

Question. How can we encourage States to be better innovators on health-care spending? The current Medicaid waivers incentivize States to keep costs down, but are there ways to encourage both lower costs and better health-care outcomes?

Answer. A shift toward a value-based approach and away from the fee-for-service system is the most effective way to lower overall costs while encouraging better health-care outcomes. We need to align payments with the goals of the health-care system, and the best way to do this is to reduce the barriers to success in value-based care arrangements. If it were simpler for practices to participate and succeed in risk, more would adopt the models that incentivize outcomes—better care quality, improved patient experience, and lower costs—rather than volume of services provided.

QUESTIONS SUBMITTED BY HON. MAGGIE HASSAN

Question. We spoke during the hearing about the incentive payment for providers to improve tracking and reporting of opioid prescribing, treatment agreements, follow-up evaluations, and screening of patients who may be at risk of opioid misuse under the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA).

This data has the potential to improve treatment for substance use disorder, which is why its collection and reporting is now incentivized through increased reimbursement.

At the hearing, I asked for feedback on the impact this data collection and reporting has had on treatment of patients, particularly as it relates to any reduction in opioid misuse.

Based on your response, it seems that there may be additional steps the Centers for Medicare and Medicaid Services (CMS) could take so that this aggregated, de-identified data can be used to benefit patients and improve care.

Do you have specific suggestions on how CMS can improve the collection, use, and dissemination of opioid prescribing and treatment data sets in ways that would directly benefit patients at their site of care, specifically as it relates to identifying best practices to reduce opioid misuse?

Answer. CMS can improve the collection, use, and dissemination of opioid prescribing and treatment data sets in ways that would directly benefit patients at their site of care, specifically as it relates to identifying best practices to reduce opioid misuse, by supporting 42 CFR part 2 reform efforts.

42 CFR part 2 requires limiting the use and disclosure of patients' substance use records from certain substance use programs. Under current law, a patient must provide written authorization permitting each individual provider access to their substance use disorder records. A lack of access to the full scope of medical information for each patient can result in the inability of providers and organizations to deliver safe, high-quality treatment and care coordination. The Health Insurance Portability and Accountability Act (HIPAA) grants providers access to a wide range of patient data to manage population health, while still maintaining patient privacy protections. AMGA requests that Congress align the 42 CFR part 2 law with HIPPA to alter access to patients' substance use information. This policy proposal would grant providers access to this data to manage population health, while still maintaining patient privacy protections, such as identifying opioid misuse.

QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO

Question. In 2011, REMSA, an EMS provider in Northern Nevada, received innovation grant funding from CMMI. The program was incredibly successful—they avoided re-hospitalizations, and improved county-wide health outcomes. In addition, they saved $9 million for the Medicare program. In 2020, CMS will launch ET3, a national model based on the REMSA program.

Do we have an adequate process to transition demonstrations from innovation grantees to national models?

Answer. At this time, I am not certain that we do have an adequate process.

One example is participants in the Federal Accountable Care Organization (ACO) program, which has made significant improvements in care processes and the deliv-

ery of high-quality care, while reducing health-care utilization. Although many ACOs have improved the quality of care and saved Medicare dollars, program results have been uneven at best. ACOs have encountered significant obstacles in program design that threaten not only their own success, but also the future viability of this program.

Question. What are some of the lessons from the success of your larger practices in complying with MIPS or transitioning to APMS? Are they applicable to small and rural groups that are eligible for technical assistance? If so, how can we share them with those groups?

Answer. Crystal Run Healthcare was founded in 1996 in Orange County New York, which is three counties north and west of New York City. This is a fairly rural region, but in 2002, we expanded one county north to Sullivan County, which is rural and underserved. We recruited 40 providers and built a 60,000 square foot facility that houses physician offices, a lab, radiology and urgent care. Those rural and underserved patients were able to experience the benefits of coordinated care in an integrated model similar to that of most AMGA member organizations.

With the proper incentives, such as eliminating MIPS exclusions and eliminating arbitrary APM thresholds and possibly others, providers in rural areas could work with larger organizations to be able to tap into this model of care. Rather than preserving the status quo (a broken, uncoordinated, expensive fee-for-service system), we should be incentivizing rural providers to collaborate with organizations that have experience delivering care in this new manner. This is not to say that rural providers need to join larger entities. Each provider can decide for themselves what the nature of that relationship should be. However, if the incentives are adequate integration will occur.

PREPARED STATEMENT OF BARBARA L. MCANENY, M.D.,
PRESIDENT, AMERICAN MEDICAL ASSOCIATION

The American Medical Association (AMA) appreciates the opportunity to present our views to the U.S. Senate Committee on Finance. As the largest professional association for physicians and the umbrella organization for State and national specialty medical societies, the AMA has invested heavily in efforts to achieve successful implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Since the enactment of MACRA, the AMA has worked closely with both Congress and the Centers for Medicare and Medicaid Services (CMS) to promote a smooth implementation of the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) under the Quality Payment Program (QPP). We continue to believe that MACRA represents an improvement over the flawed sustainable growth rate (SGR) payment methodology. However, the implementation of a new Medicare quality and payment program for CMS and physicians has been a significant undertaking, and further refinements are still needed to improve the program and reduce administrative burden for physicians.

MACRA included modest positive payment updates in the Medicare Physician Fee Schedule, but it left a 6-year gap from 2020—next year—through 2025 during which there are no updates at all. Following this 6-year freeze, the law specifies physician payment rate updates of 0.75 percent or 0.25 percent for physicians participating in APMs or MIPS, respectively. By contrast, other Medicare providers will continue to receive regular, more stable updates.

The recent "2019 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds" ("Medicare Trustees Report") found that scheduled physician payment amounts are not expected to keep pace with the average rate of physician cost increases, which are forecast to average 2.2 percent per year in the long range. The Medicare Trustees Report also found that "absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."[1] The AMA agrees and urges

[1] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. (April 22, 2019). "2019 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds." Retrieved from *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Trustees-Reports-Items/2016-2019.html.*

Congress to replace the upcoming physician payment freeze with annual positive payment updates over the next several years to provide physicians with a stable and sustainable revenue source that allows them a margin to invest in practice improvements in order to transition to more efficient models of care delivery to better serve Medicare patients.

One goal of MACRA was to provide physicians with a glide path to transition into APMs. To help facilitate this transition, Congress provided a 5-percent bonus for physicians who participate in Advanced APMs during the first 6 years of the program. Unfortunately, through the first 3 participation years—half the time this bonus was to be available—few physicians have had the opportunity to participate in Advanced APMs. Consequently, the AMA is urging Congress to extend the Advanced APM bonus payments to fulfill Congress's original intent and provide support to physicians as they transition to new payment models.

In addition to a sustained glide path to allow physicians to transition to APMs, the AMA urges Congress and CMS to continue to make MIPS more meaningful for physicians. We hear from our physician members that there is no link between many of the MIPS measures they are required to report and improving clinical care for their patients. The AMA has engaged the physician community through workgroups to develop creative solutions to simplify and streamline the QPP, while making it more meaningful for physicians. We look forward to working with Congress and CMS to implement some of these creative solutions and continue to improve MIPS.

IMPROVEMENT OVER LEGACY PROGRAMS

The AMA was supportive when Congress replaced the flawed, target-based SGR formula with a new payment system under MACRA in 2015. Scheduled payment cuts prior to the implementation of MACRA exceeded 20 percent. Those cuts would have had a devastating impact on physician practices and patient access to care. Under MACRA, the SGR formula was replaced with specified payment updates for 2015 through 2019 and for 2026 and beyond. MACRA also created an opportunity to address problems found in existing physician reporting programs. In addition, the law sought to promote innovation by encouraging new ways of providing care through APMs.

Support for Technical Corrections

The AMA strongly supported the changes to MACRA in the Bipartisan Budget Act of 2018 (BBA18). These technical changes helped many practices avoid penalties that they likely would otherwise have incurred under the MIPS program. Specifically, we commend Congress for excluding Medicare Part B drug costs from MIPS payment adjustments, as including these additional items and services created significant inequities in the administration of the MIPS program. In addition, we appreciate the flexibility given to CMS to reweight the Cost performance category to not less than 10 percent for the 3rd, 4th, and 5th years of MIPS, and to set the performance threshold for 3 additional years. As Congress intended, we believe the goal of the program should be to help physicians succeed, not to cause physicians to fail, and we believe these technical changes, along with other changes, will allow CMS to increase the program requirements gradually and transition to a more meaningful program over time.

We also appreciated the BBA18 provision that allowed the Physician-focused Payment Model Technical Advisory Committee (PTAC) to provide initial feedback to proposal submitters. Unfortunately, the PTAC has indicated that it is still not able to provide technical assistance and data analyses to stakeholders who are developing proposals for its review. Additional technical corrections may be needed to provide the PTAC with more flexibility in this regard.

Support for Small and Rural Practices

The AMA appreciates the accommodations for small practices that are included MIPS. Specifically, the low-volume threshold exemption excludes numerous small practices or physicians who see very few Medicare patients. In 2018, physicians with annual Medicare allowed charges of $90,000 or less or 200 or fewer Medicare patients were exempt from the QPP altogether. In 2019, CMS extended the low-volume threshold to physicians who provide 200 or fewer covered professional services to Medicare Part B beneficiaries. The AMA has also supported reduced reporting requirements for small practices, hardship exemptions from the Promoting Interoperability MIPS performance category for qualifying small practices, bonus

points for small practices, and technical assistance grants to help small and rural practices succeed in the program.

Despite these improvements, the AMA and our physician members still have significant concerns regarding the ability for small and rural practices to succeed in the MIPS program. In 2017, the national mean and median scores for all MIPS eligible clinicians were 74.01 and 88.97 points. However, the mean and median scores for rural and small practices were 43.46 and 37.67, and 63.08 and 75.29, respectively. Given the lower scores achieved by small and rural practices compared to all MIPS eligible clinicians, the AMA urges Congress and CMS to continue to implement policies that help small and rural physician practices succeed in MIPS.

GLIDE PATH INTO APMS

Extend the Advanced APM Bonus

MACRA was intended to create a gradual glide path to move physicians into more innovative value-based care payment models. Changing the way physicians deliver care requires significant investment into new technologies and workflow systems. In order to help physicians implement these changes, MACRA provided a 5-percent bonus for the first 6 years of the program for physicians who participate in an Advanced APM. These bonus payments were intended to create a margin for physicians to invest in changing the way they deliver care. We heard from many physician groups who were excited to take advantage of the opportunity to move to an Advanced APM.

Unfortunately, there were a limited number of Advanced APMs in which physicians could participate during the first 3 MACRA performance years, and there are only 3 years left in the program for physicians to receive an APM bonus. The dearth of Advanced APMs available for physicians limited their ability to take advantage of the APM bonus that Congress provided to assist physicians with moving to new, innovative payment models.

The AMA is greatly encouraged by the recent steps taken by Department of Health and Human Services Secretary Azar, CMS Administrator Verma, and Center for Medicare and Medicaid Innovation (CMMI) Director Boehler. They are working to implement and further develop new models based on stakeholder proposals to the PTAC. We believe there will be increased opportunities for physicians in various practice group sizes and specialties to participate in Advanced APMs as CMMI continues to release new models. However, given the small number of physicians who have been eligible to receive the APM Qualified participant (QP) bonus to date, the AMA strongly urges Congress to extend the APM bonus for an additional 6 years to provide physicians a realistic onramp to participation in value-based care. As CMMI continues to test and develop new models, the AMA hopes that physicians will have access to APMs that give them the resources and flexibility to redesign the delivery of patient care and support their efforts to achieve good health outcomes.

Modify Thresholds to Achieve QP Status

In addition to extending the period of time that the QP bonus payments are available to APM participants, the AMA recommends that Congress revisit the payment thresholds set by MACRA. Under current law, these thresholds escalate from 25 percent to 75 percent of APM participant revenues over a 5-year period. Many APM participants are concerned that these thresholds are too high, especially for episode-based APMs. MACRA set the payment thresholds but gave limited authority to CMS to set patient thresholds to achieve QP status. The AMA recommends that CMS' statutory authority be expanded so it can set both the payment and patient thresholds for QP status and could set different thresholds for different types of APMs.

Further Improvements Are Needed

The AMA urges Congress to make additional technical changes to MACRA to simplify the program and make reporting more clinically meaningful for physicians. We were pleased CMS established transition policies for the first year of MIPS and, as a result, 93 percent of eligible clinicians received a modest positive payment adjustment and nearly three-quarters qualified for an additional exceptional performance bonus. However, we continue to hear from physicians that the program needs to be streamlined and more clinically relevant. To assist Congress and CMS in making the program cohesive and meaningful to physicians and patients, the AMA convenes MIPS and APM workgroups made up of representatives from across the physician community, which have developed creative solutions to improve the QPP. These so-

lutions include ways to simplify scoring, create more integrated approaches to reporting across performance categories, and improve the physician reporting experience.

For example, Congress and CMS can make MIPS more cohesive and meaningful to physicians and patients by allowing physicians to focus their participation around a specific procedure, condition, or public health priority. By allowing physicians to focus on activities that fit within their workflow and address their patient population needs, rather than focusing on segregated activities that fit into the four disparate MIPS categories, the program could improve the quality of care and be more meaningful and less burdensome for physicians. The AMA has worked closely with the physician community to develop a streamlined MIPS participation option that would hold physicians accountable for the cost and quality of care around a specific episode. For instance, a cardiologist could participate in a MIPS episode evaluating cost and quality using valid and reliable measures, as well as health IT use, around Percutaneous Coronary Intervention procedures and primary care physicians could focus on lowering costs and improving quality by maximizing patient engagement through a Patient-Centered Medical Homes. This participation option in MIPS would also be a bridge to APMs by giving physicians an opportunity to gain experience and see their data before taking on financial risk in a bundled payment or advanced primary care model.

Additional suggestions for technical changes to improve MACRA from the work groups include:

- Updating the Promoting Interoperability performance category to allow physicians to use certified electronic health record technology (CEHRT) in more clinically relevant ways;
- Developing a separate threshold for small and rural practices to ensure a level playing field for all physicians;
- Prioritizing cost measures that are valid and actionable and that have stronger correlation between costs and the physicians' influence over those costs;
- Incentivizing reporting on new quality measures, especially specialty developed and recommended measures;
- Eliminating the requirement to set the performance threshold at the mean or median so CMS, rather than a pre-set formula, can determine whether physicians are ready to move to an increased threshold based on available data; and
- Aligning and improving the methodologies of MIPS calculations and Physician Compare. Currently, physicians receive two different scores and reports, which is confusing to physicians and patients and does not lead to quality improvement.

The QPP is a complex program that remains complicated for CMS to implement and difficult for physicians to understand; however, the AMA is confident that if Congress, CMS, and the medical community continue to work together to improve the program, we can ensure physicians have the opportunity to be successful and provide high-value care to patients.

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

QUESTIONS SUBMITTED FOR THE RECORD TO BARBARA L. MCANENY, M.D.

QUESTIONS SUBMITTED BY HON. ROB PORTMAN

Question. I introduced the Medicare Care Coordination Improvement Act with Senator Bennet in an effort to reduce some of the barriers that providers face when they participate in alternative payment models. However, one particular section of my bill focuses on providing temporary waivers to practices that are interested in testing their own APMs. HHS has been slow to take up new APM concepts, and thus: what can we do to incentivize the establishment of new APMs? Has the PTAC offered a viable way to propose and test new APMs? If not, what actions could be taken to encourage the adoption of PTAC models?

Answer. First, the AMA strongly supports the Medicare Care Coordination Improvement Act of 2019 because it would increase care coordination for patients, improve health outcomes, and reduce spending by allowing physicians to participate

and succeed in APMs. The vision of greater APM adoption can only be achieved if antiquated laws like Stark, which are based on outdated treatment delivery schemes, are modernized; the Act would help advance this vision.

Tying compensation to the value of care provided, equipping providers with tools to improve care especially when that involves development of lower cost imaging centers or labs that are imbedded in the APM structure, and investing in software and care coordination tools to clinically and financially integrate, may run afoul of the Stark law. Specifically, in certain circumstances, it prohibits physicians from providing innovative services such as transportation or other services of value to their patients. Instead, the patient, in addition to dealing with the physical and emotional aspects of a disease or condition, must also attempt to coordinate their own care in a fragmented and siloed system. Accordingly, the AMA has urged Congress to create a Stark exception and anti-kickback safe harbor to facilitate coordinated care and promote well-designed APMs. This exception should be broad, covering both the development and operation of a model to allow physicians to transition to an APM model, and provide adequate protection for the entire care delivery process to include downstream care partners, entities, and manufacturers who are linking outcomes and value to the services or products provided.

Second, AMA has also strongly supported the PTAC since its creation in MACRA. The PTAC was designed to allow physicians to develop and implement new payment models that would support the services physicians feel are necessary and provide accountability focused on aspects of quality and cost that physicians can control.

There continue to be a limited number of APMs in which physicians can participate during the first 3 MACRA performance years. However, the AMA has recently been greatly encouraged by steps taken by the Center for Medicare and Medicaid Innovation (CMMI) that illustrate it is working to implement and further develop new models based on PTAC proposals.

In order to ensure that physicians continue to be incentivized to develop APMs, we urge Congress to extend the APM bonus for an additional 6 years, which would allow physicians more of a realistic onramp to develop and move into new payment models. Given the limited number of APMs tested and approved to date, physicians need an extension of the APM bonus to allow them to experiment with new models and change the way they deliver care.

We also recommend that Congress make technical corrections to MACRA that would give the PTAC explicit authority to provide data analyses and technical assistance to stakeholders developing physician-focused APM proposals. A provision of the Bipartisan Budget Act of 2018 allows PTAC to provide initial feedback to proposal submitters, but PTAC has been barred from providing the types of data analyses and technical assistance that could help stakeholders develop proposals that CMMI would be more readily able to implement.

We appreciate Congress's continued efforts to work with CMS and the physician community to ensure there are sufficient numbers of APMs for physicians to choose from.

Question. Per data from CMS, about half of all Medicare providers are participating in MIPS, with the majority of these non-participating providers being exempt via the low-volume threshold. While we don't want to place additional burdens on small and rural providers, we should be identifying ways to engage with these practices to help them transition towards value-based outcomes.

What actions should be taken to engage with these providers?

Answer. The AMA continues to believe the simplest way to ensure small and rural practices remain viable is to maintain the low-volume threshold. To eliminate or reduce the threshold, and force physicians to participate in MIPS, when they see such few Medicare patients, could cause small and rural practices to close.

If Congress's goal is to help these small practices transition into value-based outcomes, it should focus on ensuring the development and implementation of APMs are realistic for small practices to implement. This may require multiple small pilot models to determine what will best meet the goals of patients and CMS. In addition, the extension of the APM bonus payments, as mentioned above would provide a more realistic onramp for small practices to start implementing APMs.

Finally, Congress should revisit the APM Qualifying Participant (QP) payment thresholds set by MACRA. It is unrealistic for many small practices to escalate from 25 to 75 percent of APM participant revenues over a 5-year period. These thresholds

are especially difficult to achieve for practices that implement episode-based APMs. Therefore, the AMA has recommended that CMS' statutory authority be expanded so it can set both the payment and patient thresholds for QP status and set different thresholds for different types of APMs.

In addition, the costs of compliance with MIPS reporting criteria need to be addressed. As I mentioned in my testimony, my practice scored 100 percent on MIPS but the increase in payments was $104,000 less than the cost of achieving that score.

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. The Independence at Home demonstration, which was expanded and extended last year through the CHRONIC Care Act, enables care teams to deliver high-quality primary care to Medicare beneficiaries in the comfort of their own homes. In its third performance year, according to the Centers for Medicare and Medicaid Services (CMS), Independence at Home saved $16.3 million for the Medicare program.[1] A recent evaluation also found that Independence at Home has resulted in fewer emergency department visits leading to hospitalization, a lower proportion of beneficiaries with at least one unplanned hospital readmission during the year, and a reduced number of preventable hospital admissions.[2]

As I mentioned at the hearing, I am committed to building on the success of the Independence at Home demonstration. As discussed at the hearing, I understand that the new Primary Care First model recently announced by CMMI (the Center for Medicare and Medicaid Innovation at CMS) may provide an avenue to expand access to home-based primary care for more Medicare beneficiaries.

Based on your members' experience in Independence at Home and other Alternative Payment Models, what key components will be necessary in order for the Primary Care First model to expand access to home-based primary care?

Answer. The AMA is happy to work with you and your colleagues to expand access to home-based primary care. The AMA continues to support the Independence at Home (IAH) Demonstration Program, which has already produced savings to the Medicare program as well as improved health outcomes among a beneficiary population that is medically fragile with high acuity. The comprehensive approach and flexibilities provided by the IAH Demonstration have established a proven method for providing care in less costly settings that enhance the quality of patient care. Notably, IAH teams that include a physician and have an established relationship with a hospital are able to provide the most comprehensive, coordinated care, particularly for patients with complex comorbidities.

Question. What other specific policies would you recommend Congress or CMS consider to expand access to home-based primary care for more Medicare beneficiaries?

Answer. In order to improve home-based primary care and access to timely medical treatment for Medicare's most vulnerable and high acuity beneficiaries, the AMA strongly urges Congress to provide access to medically necessary and timely clinical services by lifting statutory restrictions on telehealth. The AMA recommends that Congress amend section 1834(m) of the Social Security Act to waive the geographic and originating site limitations for such services for home-based primary care. Currently, most Medicare beneficiaries are not eligible to receive telehealth services. A limited subset of Medicare beneficiaries are eligible for telehealth services that CMS has determined are clinically appropriate to be delivered via telehealth. The beneficiary must reside in a qualifying rural geographic location. Furthermore, even those who reside in a qualifying geographic location in most instances are precluded from receiving such services in their home. Counterintuitively, a Medicare beneficiary must travel to a qualifying facility such as their physician's office or the hospital in order to receive telehealth services.

Section 1834(m) was fashioned at a time when telehealth was primarily used to provide access to medical specialty services in rural underserved communities and the technology to enable reliable, high quality two-way audio-visual real time communications was limited to health facilities. The dramatic advances in digital technology and rapid dispersion of such technologies obviate the concerns that initially

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[1] *https://innovation.cms.gov/Files/fact-sheet/iah-yr3-fs.pdf.*
[2] *https://innovation.cms.gov/Files/reports/iah-rtc.pdf.*

prompted Congress to prescribe the section 1834(m) limitations. The restrictions have chilled the uptake and use of telehealth services as part of continuum of services a medical practice may offer to high acuity and medically complex beneficiaries, particularly those who receive home-based primary care. The limited Medicare coverage is in sharp contrast to commercial insurers and other Federal health-care programs like the Veterans Health Administration and Department of Defense that have moved forward to expand coverage of telehealth services. These Federal health-care programs moved forward to expand coverage because the evidence base has grown demonstrating both clinical efficacy for various telehealth services as well as overall reduction in costs through improved triage, reduction in emergency department visits, and reductions in hospitalization along with improved care coordination and communication.

Coordination of care between primary and specialty care is an essential part of keeping complex Medicare patients out of the hospital. Removing the restriction on telemedicine for both primary and specialty care would facilitate multidisciplinary care and extend the effective reach of the primary care physician.

For the past several years, the AMA has urged CMS to undertake telehealth demonstrations that waive these restrictions to evaluate whether expansion is warranted under CMMI authority. We have recommended a request for proposal(s) for demonstrations to evaluate the telehealth services Medicare currently covers (albeit with restrictions) by waiving those statutory geographic and/or originating site restrictions. Also, the demonstrations should be sufficiently large (*e.g.,* several regions or multiple States) to provide sufficient claims data to evaluate whether telehealth is cost saving or cost neutral without the restrictions. At a minimum, we urge Congress to require CMS to undertake a demonstration to waive the originating site restrictions for Medicare beneficiaries who live in an eligible geographic location to assess cost savings or neutrality of delivering such services while beneficiaries are at home. This will provide increased access for beneficiaries in qualifying rural locations. CMS would not only be able to expand coverage where such services are cost neutral or cost saving while maintaining or improving clinical care, but this would also generate essential claims data needed by Congress and the Congressional Budget Office to develop more accurate cost estimates based on the Medicare patient population that will be informative for other services.

We strongly urge Congress, however, to lift the geographic and originating site restrictions for Medicare beneficiaries receiving home-based primary care when received as part of a continuum of services (both in-person and virtual) in a coordinated manner with an established medical home. This patient population is the most likely to benefit from enhanced access to care. Telehealth provides the care team and caregivers additional options to ensure that these medically complex patients have access to the right care, at the right time.

In addition to IAH and other primary care models, we also need to better support specialists who work with primary care physicians to manage patients with chronic conditions. For example, the American College of Physicians developed a "medical neighborhood" model to help support the teams of primary care physicians and specialists who are often needed to manage patients with chronic diseases. A model was also submitted to the PTAC recently that would support teams of primary care physicians and pulmonary or allergy specialists in managing patients with asthma.

Question. As I mentioned during the hearing, I often hear from seniors in Oregon that they don't feel like anyone is in charge of managing their health care and helping them navigate the health-care system. I am proud of the bipartisan work that this committee did on the CHRONIC Care Act last Congress to update the Medicare guarantee. In my view, the next step should be making sure that all Medicare beneficiaries with chronic illnesses have someone running point on their health care—in other words, a chronic care point guard—regardless of whether they get their care through Medicare Advantage (MA), an accountable care organization (ACO) or other alternative payment model, or traditional fee-for-service Medicare.

For beneficiaries in traditional, fee-for-service Medicare, what can be done to improve care coordination and make sure their physicians and other health-care professionals are all talking to each other and working together to provide the best possible care to those beneficiaries? What specific policies would you recommend this committee pursue toward that end?

Answer. The health-care system is moving to a world that pays health professionals to manage episodes of patient care in a more comprehensive way. However, this approach to payment can run afoul of the fraud and abuse laws. For example,

even if the primary purpose of an arrangement is to improve patients' health outcomes, as long as one purpose of the arrangement's payments is to induce future referrals, the fraud and abuse laws are implicated (*e.g.,* an arrangement that pays for a nurse coordinator to coordinate a recently discharged patient's care among a hospital, physician specialists, and a primary care physician may induce future referrals to the primary care physician to avoid an unnecessary readmission to the hospital).

Fostering the shift to APMs has necessitated reviewing and, in some situations, updating fraud and abuse laws to ensure that they do not unduly impede the development of value-based payment. Through specific statutory authority, both the CMS and the Office of Inspector General (OIG) have deemed it necessary to waive the requirements of certain fraud and abuse laws to test the viability of innovative models that reward value and outcomes.

Outside of those models, however, the fraud and abuse laws may still pose barriers to initiatives that align payment with quality and improve care coordination. Tying compensation to the value of care provided, equipping providers with tools to improve care, and investing in tools to clinically and financially integrate all may run afoul of these laws. For example, the Stark law impedes sharing needed resources between multiple physicians caring for the patient which prohibits physicians from coordinating care on behalf of their patients. Instead, the patient, in addition to dealing with the physical and emotional aspects of a disease or condition, must also attempt to coordinate their own care in a fragmented and siloed system. Placing the obligation on the patient to know how to properly manage follow-up care without the assistance of their physician or care coordinator may have a negative impact on patient care and the physician-patient relationship.

Accordingly, the AMA has urged Congress and the administration to create a Stark exception and anti-kickback safe harbor to facilitate coordinated care and promote well-designed APMs. This exception should be broad, covering both the development and operation of a model to allow physicians to transition to an APM model, and provide adequate protection for the entire care delivery process to include downstream care partners, entities, and manufacturers who are linking outcomes and value to the services or products provided.

Successfully navigating health care will also require consistent access to the right information at the right time about the right individual. This is an overarching need by both patients and physicians. Often the term interoperability is used which makes this seem a purely technical issue. In actuality, physicians want information that is pertinent to their clinical needs and that they can trust is accurate. Patients want to ensure that their physicians have access to their medical records and have assurances that their medical information is safe, private, and secure.

The AMA supports several proposals by HHS to address technical aspects of EHR interoperability issues. Yet, both patients and physicians are concerned that the recent information blocking proposals will not improve the access, use, and exchange of information. Rather, as proposed, HHS's rules may ultimately compromise patient privacy, increase the likelihood of cyber-attacks in health care, overwhelm patients with information that may not be useful, and undermine physician clinical decision-making. The AMA urges Congress to take a close look at the unintended consequences of HHS's information blocking and interoperability proposals and recommends Congress use its oversight role to ensure the goal of care coordination is achieved without sacrificing patients' rights in the process.

Furthermore, to improve utilization of chronic care management (CCM), transitional care management (TCM), and other care management services by Medicare patients, the AMA recommends that Congress eliminate the cost-sharing requirements for these services. Although utilization of CCM and TCM has been increasing in recent years, patient cost-sharing remains a barrier. Trying to promote patient participation in a care management program, and then having to talk about patients' cost-sharing obligations, puts physicians in an uncomfortable position. As a result, patients are reluctant to consent to participate in care management programs, and if they do, they frequently complain about the cost. These concerns often lead to them withdrawing from the program. By removing the cost-sharing obligations from the care management codes, more Medicare beneficiaries will benefit from the care coordination and case management services these codes support.

Question. Please describe the specific steps that Congress and/or CMS could take to ensure all Medicare beneficiaries with chronic illnesses, including those in traditional fee-for-service Medicare, have a chronic care point guard.

Answer. Congress or the administration can take the following steps to ensure a chronic care point guard:

1. Update the fraud and abuse laws so that a chronic care point guard is not considered remuneration.
2. Make meeting the requirements of the promoting access to care exception under the Civil Monetary Penalties (CMP) be a permissible activity that would not be subject to the anti-kickback statute liability.
3. Allow for the waiver of cost-sharing amounts for chronic care management services and when the amount to collect the cost-sharing amount is less than reasonable collection efforts.

With Medicare beneficiaries with chronic illnesses, the AMA has concerns about the ability of financial arrangements to satisfy anti-kickback safe harbors that involve shared savings or incentive payments being distributed based on the value of care provided by physicians either in a group or independent practice. For example, a financial arrangement that is based on managing patients with a chronic disease rewards an individual physician for properly coordinating care with a chronic care point guard or nursing staff and intervening proactively with a patient to prevent unnecessary hospitalization. This reward can be interpreted as running afoul of the anti-kickback statute as remuneration in return for referring an individual for an item or service that is payable under a Federal health-care program (*i.e.,* referral for a follow-up primary care visit in lieu of an unnecessary hospitalization).

The AMA is also concerned about potential anti-kickback statute liability for arrangements and activities that fall within the exceptions from the definition of remuneration under the CMP law. Specifically, the exception from the beneficiary inducement CMP for remuneration that promotes access to care and poses a low risk of harm could implicate anti-kickback statute liability. This means that although a physician meets the requirements of an exception under the CMP law, the physician is still liable under the anti-kickback statute. For example, beneficiaries being provided a dedicated mobile treatment plan app that allows for daily engagement with the physician and ensures greater compliance with agreed to evidence-based treatment plans so that early intervention can be taken to avoid unnecessary hospitalizations and emergency room visits fits within the exception from remuneration because it helps beneficiaries access care by improved future care-planning by their physician. However, the arrangement is still subject to anti-kickback statute liability.

The promoting access to care exception from remuneration already includes the concept of posing a low risk of harm to patients and the Federal health-care programs, OIG has already placed the burden of demonstrating low risk of harm under the CMP onto health-care providers,[3] and using the Advisory Opinion process for a case-by-case determination for every instance of a beneficiary incentive is an impracticable solution. Moreover, these incentives help deliver higher quality, better coordinated care; enhance value; and improve the overall health of patients and should not be subject to the anti-kickback statute when posing a low risk of harm to patients. Thus, Congress should consider legislation that meeting the requirements of the promoting access to care exception from remuneration would be a permissible activity that would not be subject to the anti-kickback statute.

Cost-sharing obligations are particularly problematic with chronic care management (CCM) services. Patients may be discouraged from taking advantage of this high-value service due to the cost-sharing amounts. Congress should create a safe harbor to waive cost-sharing amounts for CCM and other high-value services that may save money through better care coordination, improved patient outcomes, and avoiding unnecessary hospitalizations. This safe harbor could be tied to APMs that are focused on managing chronic conditions where the cost-sharing amount may discourage a patient from seeking primary care. Removing this unnecessary impediment to the physician-patient relationship could return impressive results. Regular appointments allow providers to more closely monitor patients and identify complications before they require hospitalization and to establish a more regular, wellness-based relationship between physician and patient. This can encourage the patient to reach out to a physician before resorting to more costly options such as calling an ambulance.

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[3] *See* 81 Fed. Reg. 88368, 88391 (December 7, 2016).

Additionally, cost-sharing obligations are also problematic when the costs associated with reasonable collection efforts exceeds the cost-sharing amount that would be potentially collected. Thus, Congress should clarify that an exception exists from the definition of remuneration under the CMP to allow for the waiver of cost-sharing amounts when the cost-sharing amount is nominal. For example, CMS expanded Medicare coverage to include services like virtual care visits. CMS pays approximately $15 for a virtual check-in service.[4] With a 20-percent cost-sharing amount, a beneficiary would pay approximately $3. As defined by CMS and OIG, the costs of any "reasonable collection effort" would far exceed the $3 collected.[5] Requiring such efforts creates waste, adds unnecessary administrative burdens, and inappropriately increases costs to physician practices. Thus, Congress should clarify that the "reasonable collection efforts" under section 1128A(i)(6)(A)(iii)(II) of the Social Security Act do not include situations where the costs of the collection efforts by the provider exceeds the cost-sharing amount that would be potentially collected.

In addition, Congress and CMS have several opportunities to refine the Medicare Access and CHIP Reauthorization Act (MACRA) to promote care coordination for Medicare beneficiaries. In a recent letter to congressional leaders, the AMA and 120 national specialty and State medical societies outlined several refinements, including:

- Replace the upcoming Medicare physician pay freeze with a stable and sustainable revenue source that allows physicians to sustain their practice and provides a margin to invest in the practice improvements needed to transition to more efficient models of care delivery and better serve Medicare patients;
- Extend the Advanced APM payments for an additional 6 years to provide physicians with an onramp to move to APMs once they become available, as intended in the original legislation; and
- Simplify the MIPS by allowing physicians to focus their participation around a specific episode of care, condition, or public health priority to address the needs of their patient population.

Question. Eligible clinicians who receive a certain percentage of their payments or see a certain percentage of their patients through Advanced APMs are excluded from MIPS and qualify for the 5-percent incentive payment for payment years 2019 through 2024. Starting this year (performance year 2019), eligible clinicians may also become qualifying APM participants (and thus qualify for incentive payments in 2021) based in part on participation in Other Payer Advanced APMs developed by non-Medicare payers, such as private insurers, including Medicare Advantage plans, or State Medicaid programs.

Recognizing that this is the first year in which the All-Payer Combination Option is available, how many of your members do you anticipate will take advantage of the All-Payer Combination Option this year?

Answer. As currently implemented, the All-Payer Combination Option hurts more than helps physicians in achieving Qualifying Participant (QP) status. Under this option, participation in APMs is measured as a percent of nearly all payers, including Medicaid, Medicare Advantage, commercial payers, and others, rather than as a percent of payers with value-based care programs that meet CMS's definition of an Advanced APM. We urge Congress to change this so that participating in Other Payer APMs adds to Medicare Part B APM participation and helps physicians reach the QP thresholds.

Question. What, if any, challenges have your members faced when attempting to take advantage of the All-Payer Combination Option?

Answer. Many payers do not offer value-based care programs that meet CMS's definition of an Advanced APM. Because of this constraint, many physicians who are participating in such programs with payers, in addition to Medicare Part B Advanced APMs, are not permitted credit under CMS's rules for such participation. This is contrary to the goal of Congress to encourage physician participation in

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[4] 83 Fed. Reg. 35704, 35723, and 35786 (July 27, 2018).

[5] OIG has stated that "reasonable collection efforts" are those efforts that a reasonable provider would undertake to collect amounts owed for items and services provided to patients. 65 Fed. Reg. 24400, 24404 (April 26, 2000). In 2016, OIG cited the CMS Provider Reimbursement Manual's description of reasonable collection efforts including requiring "providers to issue a bill for the patient's financial obligation" and "other actions such as subsequent billings, collection letters, and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort." 81 Fed. Reg. 88368, 88374 (December 7, 2016) (citing CMS, Provider Reimbursement Manual, CMS Pub. 15–1, § 310).

value-based models across multiple payers. We believe Congress should modify the All-Payer Combination Option so that participating in Other Payer APMs adds to Medicare Part B APM participation and helps physicians reach the QP thresholds.

Question. In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress provided a total of $100 million over 5 years for technical assistance to MIPS-eligible clinicians in practices with 15 or fewer clinicians, focusing on rural and health professional shortage areas.

To what extent have your members utilized the services of the Small, Underserved, and Rural Support Initiative, which CMS launched using the MACRA funding to provide free, customized technical assistance to clinicians in small practices?

Answer. The AMA strongly supports the free technical assistance available for clinicians in small practices and has heard that the assistance has been helpful, but more must be done to continue to support small and rural practices. In 2017, the national mean and median scores for all MIPS eligible clinicians were 74.01 and 88.97 points. However, the mean and median scores for small practices were 43.46 and 37.67. The lower scores achieved by small practices illustrate the need for Congress to work with the CMS and the physician community to continue to support and make changes that will help small practices and solo practitioners succeed in the program. Costs for reporting must be kept low, so that the value of a high score is more than the cost to achieve it.

Question. What types of technical assistance and support have been most helpful to physicians and practices (*e.g.,* understanding program requirements, selecting appropriate measures, forming virtual groups)?

Answer. While continued technical assistance for small practices is important, the simplest way to ensure small and rural practices remain viable is to maintain the low volume threshold. To eliminate or reduce the threshold and force physicians to participate in MIPS would kill small practices. Financially, it just doesn't make sense for these practices with limited resources to invest in MACRA compliance when they have such a small Medicare patient population—less than four Medicare patients a week.

In addition, for those small practices that treat larger Medicare patient populations and participate in the MIPS program, the most helpful assistance comes in shaping the MIPS program to allow practices of all sizes to be successful. For example, the reduced reporting requirements for small practices in several of the MIPS reporting categories, hardship exemptions from the Promoting Interoperability performance category for qualifying small practices, or bonus points for small practices greatly help small practices succeed in MIPS.

EHR vendors often do not have data reporting tools that correspond to the MIPS requirements, which makes reporting very difficult and expensive. The measures need to be meaningful to the practices, which will differ depending on the practice type.

Question. As physicians continue to gain experience with the Quality Payment Program, what additional types of technical assistance would be most helpful to solo practitioners and physicians in small practices and/or to those practicing medicine in rural or underserved areas?

Answer. The AMA believes that Congress and CMS should continue to structure the Quality Payment Program so that physicians in practices of all sizes have the opportunity to succeed. Some ideas that the AMA has suggested to even the playing field between small and large practices include developing a separate performance threshold for small practices which would allow practices to be compared to other groups of a similar size with more analogous resources. The AMA has also provided detailed suggestions on how to improve virtual groups to make participation in a virtual group a viable option for small practices, including allowing groups to leverage Clinically Integrated Networks (CINs) and Independent Practice Associations (IPAs), providing protection from Stark and anti-kickback violations for virtual groups, and offering an additional incentive or bonus payment to practices participating in virtual groups until the model is tested and refined.

QUESTION SUBMITTED BY HON. DEBBIE STABENOW

Question. I am very proud of the work the bipartisan accomplishments to address Alzheimer's, including the implementation of my HOPE for Alzheimer's Act, which

required Medicare to pay for new individual care plans to support Alzheimer's patients and their families. Many of my colleagues are also cosponsors of my Improving HOPE for Alzheimer's Act, which will ensure beneficiaries and physicians know that they are able to access, and bill for, care planning under Medicare. In our last hearing on MACRA implementation, my colleagues raised the question of how we should look at quality measures in MIPS when it comes to physicians having these conversations with beneficiaries and their families and reflecting their priorities. Some have mentioned altering MIPS to make the quality measures more clinically meaningful. In what ways do you think the system would need to change to better incorporate long-term care planning and encourage physicians to have these conversations with patients?

Answer. Under the current MIPS quality structure, CMS utilizes specialty measure sets and requires reporting on a minimum set number of measures (six), which forces physicians to pick random individual measures and lumps a specialty together, regardless of sub-specialization. In addition, when quality measures are tied to cost or an episode of care, it does not necessarily ensure that the quality measures match up with the episode and can appropriately evaluate potential for stinting on care to appear low cost. We believe allowing physicians to focus on activities that fit within their workflow and address their patient population needs—and providing them with credit for those activities that span across MIPS categories—will increase participation in MIPS, allow physicians to report on measures that are more meaningful to their practice, and drive continued improvement across performance categories.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

DEVELOPMENT OF METRICS IN MACRA

Question. In your testimony, you mentioned that your physician members believe that there is no link between many of the MIPS measures they are required to report and improving clinical care for their patients. I understand that the physician community has engaged with CMS to try and make the program more meaningful to physicians and patients through more relevant quality measures.

How are clinicians from your organization involved the creation of these measures relevant to their specialties?

Answer. The American Society of Clinical Oncology (ASCO), along with many other medical specialty societies have a measure development process in place which leverages the expertise of their members on expert panels. They also provide input on the feasibility of data collection and participate in measure testing. CMS also develops MIPS quality measures through its various contractors. While the contractors may include specialists to participate on the technical expert panels, the contractors are often not very receptive to specialty feedback and the AMA urges CMS to include more specialty input throughout the measure development process.

MIPS cost measure development

The AMA appreciated the flexibility in the Bipartisan Budget Act of 2018 for CMS to gradually increase the weight of the cost category while the agency develops new episode-based measures. Over the past 2 years, CMS has taken several important steps to improve its ability to fairly and accurately measure and compare physician resource use. The AMA greatly appreciates the agency's efforts to increase clinical input into the development of new measurement tools such as patient relationship categories and episode-based cost measures.

The AMA has worked with national specialty, State and other physician groups to ensure this process involves as many physician perspectives as possible and to develop recommendations for improvements that have broad support across the profession. The AMA also works closely with a smaller set of specialty and State medical societies as part of its MIPS workgroup to provide CMS and its contractor with detailed suggestions to improve the cost measure development and refinement process.

Finally, AMA members, including a current member of the AMA Board of Trustees, have devoted substantial hours volunteering on the cost measure technical expert panels to provide clinical input about how to accurately and fairly attribute episode of care costs to physicians. As discussed in detail below, however, CMS has retained problematic population level measures that have been developed outside of this process and with less clinical input, including the total per capita cost measure.

Total cost of care is a very complex issue that cannot easily be attributed, and physicians are frustrated at being held accountable for issues beyond their control.

Question. Has CMS been receptive to your feedback when provided?

Answer. Many medical specialty societies are developing tools such as Qualified Clinical Data Registries (QCDRs), to help physicians incorporate systems of learning into their practice to improve quality of care, provider workflow, patient safety, and efficiency. For improvements to be made to quality measurement we must move beyond snapshots of care which focus on random individual measures to a learning system with a broad focus. Utilizing specialty-led QCDRs provides an opportunity to evaluate care within an entire specialty, as well as at the individual physician level. Unfortunately, CMS has not been very receptive to specialty developed measures, especially ones developed for use within a QCDR, which was the intent of the QCDR pathway in the MACRA statue. CMS' MIPS requirements and benchmark methodologies also discourage practices from reporting through a QCDR. Therefore, specialty societies have begun to stop supporting their QCDRs and developing quality measures due to the escalating burden and arbitrary nature of the vetting process and MIPS requirements that often lacks evidence and operates on unrealistic timelines and expectations. We believe the key to achieving MACRA's goals is the availability of an adequate portfolio of appropriate quality measures that allows for all physicians, regardless of specialty or subspecialty to meaningfully participate in the program.

Streamlining MIPS

Further refinements are also needed to make MIPS clinically relevant for physicians and patients. The AMA urges Congress and CMS to continue to make MIPS more meaningful for physicians. We hear from our physician members that there is no link between many of the MIPS measures they are required to report and improving clinical care for their patients. The AMA has engaged the physician community through workgroups to develop creative solutions to simplify and streamline the QPP, while making it more meaningful for physicians.

In a recent letter to congressional leaders, the AMA and 120 national specialty and State medical societies outlined several refinements to the Medicare Access and CHIP Reauthorization Act including recommendations to simplify MIPS and make reporting more clinically meaningful for physicians. For example, Congress and CMS could make the program more cohesive by allowing physicians to focus their participation around a specific episode of care, condition, or public health priority. By allowing physicians to focus on activities that fit within their workflow and address their patient population's needs, rather than segregated measures divided into four disparate MIPS categories, the program would be more likely to improve quality of care for patients, reduce Medicare spending, and be more meaningful and less burdensome for physicians.

CMS should also have explicit flexibility to base scoring on multi-category measures to make MIPS more clinically meaningful, reduce silos between each of the four MIPS categories, and create a more unified program. This provision could also allow CMS to award bonus points at the composite score level, which would allow for a simplified scoring methodology. The primary goal of this approach is to allow physicians to spend less time on reporting and more time with patients and on improving care, and to create a more sustainable MIPS program. It also creates a glide path towards participation in APMs by encouraging physicians to focus on more clinically relevant measures and activities, improvement, and providing better value care to patients. We look forward to working with Congress and CMS to implement some of these creative solutions and continue to improve MIPS.

Question. How would you assess CMS's collaboration on achieving meaningful metrics?

Answer. The AMA was instrumental in ensuring MACRA included funding authorization for quality measure development, and we appreciate CMS's efforts to streamline measures and eliminate duplication. However, we have concerns with the way CMS allocated the funding for measure development. We were hopeful that CMS would have funded small projects over multiple years to several physician-led organizations to allow for maximum participation. Instead CMS issued a single announcement in 2018 (3 years after the passage of MACRA), funding only seven projects. We were also disappointed that some of the awards were given to large provider systems, rather than physician-led organizations, and that much of the work involved re-specifying and/or re-tooling existing measures, which is traditionally work handled by CMS's Measure and Instrument Development and Support

contractors. There also does not appear to be a requirement in the cooperative agreements to require contractors to seek feedback and coordinate with specialty societies and practicing physicians.

We believe the MACRA statute intended "organizations with quality measure development expertise" to be physician-led organizations, specifically medical specialty societies and PCPI® that have devoted substantial time and resources to developing and refining quality improvement and/or measure development activities. Partnering with specialty societies and PCPI would have ensured the measures aligned with specialty guideline development, quality improvement efforts, QCDR activities and alternative payment models.

We appreciate CMS's efforts to streamline regulations with the goal to reduce unnecessary cost and burden on physicians, as well as the initial efforts to identify the highest priority areas for quality measurement and improvement to improve patient outcomes through the Meaningful Measures Initiative. We also recognize the need to move to more measures focused on outcomes; however, absent true reforms to the quality category, benchmark methodology and overall MIPS program we do not believe the Meaningful Measure Initiative is truly a reduction of administrative burden. At a minimum, if CMS would like to see immediate reduction and return on Patients Over Paperwork, we strongly urge CMS to reduce the number of quality measures a physician must report and adopt our recommendations to simplify MIPS and make the program more meaningful.

MACRA requires all physicians to participate, regardless of specialty so there must be a sufficient number of meaningful measures that all physicians can report to satisfy the quality category. Under the current MIPS quality structure, CMS utilizes specialty measure sets and requires reporting on a minimum set number of measures (six), which still forces physicians to pick random individual measures and lumps a specialty together, regardless of sub-specialization. When you tie this to cost/an episode it does not ensure that the specialty set matches up with the episode and would seem to encourage physicians to stint on care to appear low cost. No measure should ever penalize a physician for doing the right thing for patients or suggest that avoiding needed care is a good idea.

We believe allowing physicians to focus on activities that fit within their workflow and address their patient population needs—and providing them with credit for those activities that span across MIPS categories—will encourage increased participation and drive continued improvement across categories.

Question. Are there any changes in this process you would recommend?

MIPS quality category

We request that CMS ensure that current and future projects are coordinated with specialty societies and that practicing physicians are actively involved during the development, specification and testing of the measures, which follows the intent of the law. We also request that CMS require that the relevant specialty societies have a seat at the table during the measure development process, including at the time of concept. This involvement is critical across the majority of funded projects, as it is not clear the degree to which these academic institutions and others can leverage clinical expertise available to specialty societies.

To improve the QCDR process, CMS must recognize that changes to QCDRs, registries or EHRs require significant financial resources and time to plan, incorporate, and test. This time-lag limitation becomes very challenging when CMS makes annual changes to quality requirements, measure specifications or technology functionality. Absent a reduction in the number of measures a physician must satisfactorily report, the AMA does not support immediate removal of measures from the program, but would support a phased approach. Without such a process, it is extremely hard for specialty QCDR stewards to plan and fails to consider the length of time it takes to develop a measure. It is also extremely difficult for physicians to create historic benchmarks if CMS changes or removes measures on an annual basis. It is the AMA's belief that the only way to truly measure improvement and track data over time is to have a process in place that allows for longitudinal data collection and tracking.

MIPS cost category

To improve the cost category of MIPS, CMS should focus on developing episode-based cost measures with high variability and potential high impact for change at the physician level and Congress should remove the requirement that episode-based cost measures account for half of all expenditures under Parts A and B in MACRA.

In addition, we recommend removing the total cost of care measure requirement. The original Total Per Capita Cost (TPCC) measure did not receive endorsement by the National Quality Forum in 2013 for use in physician cost measurement. Problems with the measure were linked to validity, patient attribution, and holding physicians accountable for costs over which the physician has no control. Moreover, the measure holds physicians responsible for total Medicare Part A and B expenditures, including costs over which the physician has no control. In recognition of the issues with the existing TPCC measure, CMS recently pursued revisions to the measure's attribution methodology and measurement period, among other changes.

At a time when cost measurement is an immature science, the AMA appreciates CMS's willingness to revisit and refine existing cost measures. We believe, however, that the revisions to the TPCC measure do not address underlying concerns about the measure's validity and raise new problems with the attribution methodology. The revised TPCC measure retains the flawed concept of holding physicians responsible for total costs of care even for services delivered after the patient was no longer in their care and assumes that data regarding services provided by other physicians is readily available and therefore actionable by the attributed physician. The revisions to the measure also increased the risk of inappropriate attributions. For example, while certain specialists who provide specific types of services (*e.g.,* chemotherapy, radiation therapy, surgery, and anesthesia) would be exempt, a practice comprised of exempt specialists might still be subject to the measure if a physician assistant or nurse practitioner provides an office visit and has the beneficiary attributed to them as a result. We believe CMS should score physicians on episode-based cost measures that have a stronger correlation with costs that are within physicians' control and remove the TPCC measure from MIPS.

While we continue to believe that appropriately designed episode cost measures have the potential to measure costs more accurately, these measures represent a significant shift in the measurement of resource use. CMS should put in place safeguards against unintended consequences. These include:

- Phasing in new measures over several performance periods to give physicians an opportunity to understand how they will be evaluated on their resource utilization during episodes;
- Increasing the case minimums for measures to create better physician buy-in, promote more accurate benchmarks, and ensure individual physicians and small groups are not disadvantaged by a small number of outliers;
- Lowering or at least maintaining the current cost category weight at 15 percent for the next 3 years while new episode measures are developed, tested, and used in MIPS;
- Releasing more detailed analyses about how the new measures will impact physicians and groups, particularly based on group size; and
- Conducting extensive education and outreach about the new measures.

Finally, the point of the MIPS cost category is to show physicians where there are opportunities for their practice to be more efficient. However, initial MIPS feedback reports did not include the detailed patient level information that was available in the predecessor Quality and Resource Use Reports (QRUR). Physicians tell us that the QRURs were much more useful and that the QRUR drop down data should be restored in the feedback reports. It is our understanding that CMS intends to add this data in the future and we hope that the next round of feedback reports will contain additional data.

MACRA AND THE ADDICTION CRISIS

Question. During the hearing, Senator Hassan asked some important questions around the MACRA incentive payments for those who improve tracking and reporting of quality measures related to opioid prescribing and treatment. You mentioned that recognizing team-based care in the treatment of substance use disorder would be useful in the MACRA program.

Can you please elaborate on your comments during the hearing related to this issue? How can MACRA be improved to take into account team-based care more effectively and how would this improve treatment for substance use disorder?

Answer. On the APM side, the AMA and the American Society of Addiction Medicine developed a framework for an APM focused on treatment of opioid use disorder that Congress included in the SUPPORT Act last year as the basis for a federally mandated demonstration project. The AMA and American Society of Addiction Medicine talked with physicians who wanted to deliver treatment for patients with

opioid use disorder but could not do so because of the problems in the current payment system, and so we designed an APM that would correct those problems.

The AMA believes that the current approach to address the opioid crisis through quality measurement has been too narrowly focused on preventing and/or reducing opioid use in the absence of addressing the larger clinical issue—ensuring adequate pain control while minimizing the risk of opioid addiction. Quality measurement must focus on how well patients' pain is controlled, whether functional improvement goals are met, and what therapies are being used to manage pain. We recommend that CMS develop measures that examine adequate pain control with appropriate therapies of which opioids may be an option. Until such time that these broadly applicable measures are available, we do not support continued inclusion of the narrowly focused measures CMS has proposed in its quality programs.

The AMA has also recommended that CMS adopt measures in the Improvement Activities part of MIPS focused specifically on physician efforts to end the opioid epidemic, such as taking the training needed to be able to prescribe buprenorphine to treat opioid use disorder.

STARK LAW

Question. The goal of the Stark Law is to protect Medicare beneficiaries from unnecessary utilization and fraud. However, there are concerns from stakeholders that Stark Law hinders care coordination and does not align with value-based care by posing barriers to participation of physician group practices in APMs.

During the hearing, in response to one of Senator Wyden's questions, you mentioned that changes to Stark Law are necessary because it prevents small community physicians from working together to offer less expensive services to patients.

Can you please elaborate on your comments during the hearing related to this issue?

Answer. As it relates to small community practices, one issue with Stark is virtual groups. To encourage broader MIPS participation for solo practitioners and groups with 10 or fewer eligible clinicians, CMS created a virtual group option. Many solo practitioners and groups of 10 or fewer MIPS eligible clinicians have limited resources and technical capabilities. Virtual groups will involve preparation of health information technology systems and training staff to be ready for implementation, sharing and aggregating data, and coordinating workflows. While these are necessary steps to ensure the success of virtual groups, these steps could raise concerns involving Stark.

By pooling resources together to participate in MIPS, individual physicians may receive an ownership interest in the virtual group or other compensation arrangement from the virtual group (*e.g.,* disbursement of any incentive payments). Moreover, physicians may prefer to refer patients within their own virtual group to control unnecessary costs and provide higher quality care because each physicians' performance is tied to the same virtual group's MIPS score. Any of these referrals within the virtual group between physicians could violate Stark. This outcome is different from a normal "group practice" where some of these referrals are protected from Stark through exceptions.

"Virtual groups," by definition, are not "group practices" as that term is specifically defined under Stark because virtual groups do not constitute a "single legal entity." Virtual groups consist of at least two legal entities. Thus, because virtual groups do not meet this definition, the Stark in-office ancillary services exception and the physician services exception do not apply. Furthermore, the anti-kickback safe harbor for investments in group practices also does not apply. Accordingly, physicians in a virtual group with a financial relationship with such a virtual group may not be eligible to make referrals for designated health services payable by Medicare to the virtual group.

More broadly, significant changes in health-care payment and delivery have occurred since the enactment of Stark. Numerous initiatives are attempting to align payment and coordinate care to improve the quality and value of care delivered. The delivery of care is going through a digital transformation. However, Stark—in its almost 30 years of existence—has not commensurably changed.

Stark was enacted in a fee-for-service world that paid for services on a piecemeal basis. The fraud and abuse laws act as a deterrent against overutilization, inappropriate patient steering, and compromised medical judgment with heavy civil and

criminal penalties like treble damages, exclusion from participation in Federal health-care programs, and potential jail time.

The health-care system is moving to a world that pays health professionals to manage episodes of patient care in a more comprehensive way. However, this approach to payment can run afoul of the fraud and abuse laws. For example, even if the primary purpose of an arrangement is to improve patients' health outcomes, as long as one purpose of the arrangement's payments is to induce future referrals, the fraud and abuse laws are implicated (*e.g.,* an arrangement that pays for a nurse coordinator to coordinate a recently discharged patient's care among a hospital, physician specialists, and a primary care physician may induce future referrals to the primary care physician to avoid an unnecessary readmission to the hospital).

Fostering the shift to APMs has necessitated reviewing and, in some situations, updating fraud and abuse laws to ensure that they do not unduly impede the development of value-based payment. Through specific statutory authority, both the CMS and the OIG have deemed it necessary to waive the requirements of certain fraud and abuse laws to test the viability of innovative models that reward value and outcomes.

Outside of those models, however, the fraud and abuse laws may still pose barriers to initiatives that align payment with quality and improve care coordination. Tying compensation to the value of care provided, equipping providers with tools to improve care, and investing in tools to clinically and financially integrate all may run afoul of these laws. For example, the Stark law impedes care coordination by prohibiting physician groups from banding together to provide needed services. Specifically, in certain circumstances, it prohibits physicians from coordinating care on behalf of their patients. Instead, the patient, in addition to dealing with the physical and emotional aspects of a disease or condition, must also attempt to coordinate their own care in a fragmented and siloed system. Placing the obligation on the patient to know how to properly manage follow-up on care without the assistance of their physician or care coordinator may have a negative impact on patient care and the physician-patient relationship.

Accordingly, the AMA has urged Congress and the administration to create a Stark exception to facilitate coordinated care and promote well-designed APMs. This exception should be broad, covering both the development and operation of a model to allow physicians to transition to an APM model, and provide adequate protection for the entire care delivery process to include downstream care partners, entities, and manufacturers who are linking outcomes and value to the services or products provided.

Question. Congress and CMS have been considering modifying the Stark Law to promote more robust participation in APMs. If CMS waives Stark law for groups developing or operating APMs, what tools and guardrails would you recommend to ensure that the APMs developed by these groups reach 2-sided risk in a timely manner?

Answer. Congress should create a Stark exception to facilitate coordinated care and promote well-designed APMs. The financial arrangement that fits within the exception should be for the purposes of operating and developing an APM. Protecting the development of the APM is a key to help shift physicians from transitioning from MIPS to APMs. The development should cover start-up and infrastructure costs. The exception should cover any arrangement between the APM, one or more of the APM's participants, downstream care partners, entities, and manufacturers who are linking outcomes and value to the services or products provided, or a combination thereof.

Flexibility is important for innovation. Yet flexibility in a new payment system also may raise fraud and abuse concerns. To help address these concerns, the Stark exception could incorporate provisions that increased transparency and accountability through a board of director's approval; require the arrangement to be tied to the goals of the APM; and allow freedom of choice for patients by prohibiting stinting on medically necessary care. The exception should also ensure that referrals for designated health services are not being steered for market dominance or financial gain rather than for coordination of care.

While participation agreements work well in the context of specific payments models, the AMA believes they would likely be impractical for Medicare generally. As an alternative, the parties to the arrangement could set forth in writing the arrangement, their goals for patient care quality, utilization, and costs, and the items and services covered under the arrangement.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Accountable Care Organizations (ACOs) have the potential to transform our health care delivery system. While we've seen ACOs improve patient care and create shared savings, many provider-led ACOs only control a small fraction of total spending, with specialists, pharmaceuticals, and hospitals accounting for most of it. This leads to ACOs lacking sufficient leverage to bring down costs and can contribute to shared losses.

How can we improve the ACO model to account for this imbalance? How can we support successful ACOs and encourage more providers to follow their lead?

Answer. Under the new "Pathways to Success" regulation, new ACOs will only have two to 3 years in a shared savings model before they have to take on downside risk. The AMA is concerned that this policy will prevent ACOs that may have been successful in improving quality of care for Medicare patients and in saving money for the Medicare program from continuing to participate.

In addition, it is important to note that physicians who participate in ACOs are paid the same way as other physicians. They do not receive any upfront or monthly payments to support better care management services, team-based care, clinical decision support systems, or after-hours access. Without being provided any additional resources, they are asked to take financial risk for the total cost of care for thousands of patients. Changes that would help more ACOs successful include: develop better payment models for ACOs (and physicians who are part of ACOs) that provide them with the resources and flexibility needed to redesign patient care; limit downside risk to the types of costs that ACOs can actually influence or control, such as preventing avoidable hospital admissions, achieving good surgical outcomes with low complication rates, or managing chronic conditions so they do not get worse; extend the MACRA APM incentive payments for an additional 6 years; and give CMS authority to modify the thresholds for being a qualified APM participant.

Question. Our health-care system is not fully equipped to care for an aging population and patients with advanced illness such as late-stage cancer, Alzheimer's disease or dementia, or congestive heart failure. This is an area where we need new models of care that reflect these challenges and create a better system for providers, patients, and their families. Many of our current Medicare rules in this space are counterproductive, such as requiring a 2-night, 3-day stay in an inpatient facility to qualify for skilled nursing care, and various disincentives to providing respite or palliative care. How are your organizations innovating to provide care for these patients, and what can Congress and CMS do to support those efforts?

Answer. Congress and CMS should support APMs that focus on preventing hospitalizations and preventing exacerbations of these chronic conditions. Many of the PTAC proposals do this, as does the recently announced Primary Care First model. The PTAC proposal from the Renal Physicians Association is another good example. It focuses on the 6-month period when patients transition from chronic to end-stage kidney disease, a very sick population. My PTAC proposal, MASON is an attempt to improve the Oncology Care Model so that more oncology practices will be able to continue the work of aggressively managing the side effects of cancer and its treatment to lower hospitalization rates, but with an accurate target price for the parts of oncology care that the physician can control.

Congress can provide CMS with broader program waiver authority to support organizations that are innovating to provide care. Currently, CMS only has the authority to waive program waivers—like the skilled nursing facility 3-day rule—for the Medicare Shared Savings Program or for models operating under CMMI.

We recognize that the most expensive part of the health care delivery system is the hospital inpatient arena, and encouraging chronic disease management to keep patients healthy enough to remain outpatients has great potential to save money as well as manage the increasing number of elderly with multiple chronic diseases. Yet the savings currently accrues to the insurer—Medicare in this case—but the expense accrues to the practices.

Question. Despite continued investment, electronic health records (EHRs) remain difficult to share, challenging for patients to access, and a source of frustration to providers and policymakers alike. The business models of the EHR venders often leads to perverse incentives against sharing patient information.

What steps can Congress take to make EHRs work better for providers?

Answer. Four steps that Congress can take to make EHRs work better for providers:

1. Use of health information technology (health IT) beyond CEHRT for the Promoting Interoperability performance category;
2. Permit reporting by attestation to move to a more outcome-focused care;
3. Leverage EHR vendor-generated information to reduce physician burden and to meet the Federal Government's needs to collect data on EHR usage; and
4. Consider the capabilities of EHRs when developing quality measures.

USE OF HIT BEYOND CEHRT

Question. Federal policy is a major driver in EHR system design. The AMA continues to highlight that Federal reporting requirements (*e.g.,* the Quality Payment Program's Promoting Interoperability measures) are significant determinations in how EHRs look and feel to physicians. Simply put, EHR design is based on Federal reporting demands. Program requirements are too focused on physicians reporting use of EHRs as opposed to whether EHRs are useful to physicians and the care they provide to their patients. Unless changes are made, EHRs will continue to burden physicians.

Answer. As an initial step to improve physicians' experience with health IT, physicians should be allowed to use certified EHR technology (CEHRT), technology that interacts with CEHRT, and/or a qualified clinical data registry to participate in Promoting Interoperability and to be considered a meaningful user. This will reduce the demand on EHRs having to be a "one size fits all" tool. Because increased interoperability and patient access will require new combinations of technologies and services, we continue to urge HHS to reevaluate regulations that prioritize the use of CEHRT over other non-certified digital health tools. Patients, physicians, and other care team members should be empowered to make decisions based on what works best for their needs, and not what regulatory boxes must be checked. Any new Promoting Interoperability measures should allow clinicians to utilize not only CEHRT but also health IT that "builds on" CEHRT—a concept taken directly from CMS's priorities in its call for new Promoting Interoperability measures. It would not only reward doctors who seek to utilize emerging health IT for patient care or contribute data for aggregation and quality analysis purposes, but also allow additional clinicians to participate in the Promoting Interoperability category since some currently seek an exclusion because they do not use CEHRT (*e.g.,* non-patient facing clinicians such as radiologists). This would require a new clause in 1848(o)(2)(A):

> (iv) ADDITIONAL TECHNOLOGY—The eligible professional may choose whether to use certified EHR technology, technology that interacts with certified EHR technology, or may participate in a qualified clinical data registry (or a combination of all three technologies), to be considered a meaningful EHR user.

REPORTING BY ATTESTATION

Congress should direct CMS to utilize the authority it granted to the Secretary through HITECH to permit reporting in PI through yes/no attestation. Each "yes" would be worth a certain amount of points. In addition to relieving the reporting burden, an attestation-based approach would help facilitate EHR development to be more responsive to real-world patient and physician needs, rather than designed simply to measure, track, and report, and could help prioritize both existing and future gaps in health IT functionality. This can be accomplished by adding the following to 1848(q)(2)(B)(iv): "For the performance category described in (A)(iv), the requirements shall be met via attestation or other less burdensome means."

LEVERAGE EHR VENDOR-GENERATED INFORMATION TO REDUCE PHYSICIAN BURDEN

Congress should work with ONC and CMS to leverage EHR data generated as a byproduct of PI participation. EHR vendors already track and record many data points used for PI reporting, so there is no need to continue to use physicians as reporting intermediaries. For instance, CMS's "Support Electronic Referral Loops by Receiving and Incorporating Health Information" PI measure groups summary of care records received and the reconciliation of clinical information into one process. Physicians are required to manage and report both the acceptance of summary documents and the reconciliation process. This tasks physicians with juggling the technical aspect of interoperability, *i.e.,* digital document capture and incorporation, and the laborious process of reconciliation. In fact, our members view information rec-

onciliation in an EHR as "overwhelming" and adding "a lot of non-meaningful noise" to their patients' charts.

Instead of focusing on EHRs as a tool for measuring physician actions, more clarity is needed on whether the EHR was able to use the summary of care document without burdening the physician, whether the EHR was able to provide the physician with usable and actionable clinical information in a format that supports clinical decision making, and if the EHR enabled a closed-loop referral. Essentially, more needs to be done to understand how EHRs actually function and should function in the real world. This type and level of information is far more meaningful and valuable to physicians, CMS, and ONC, and should be what Federal EHR reporting programs promote. Analyzing this information would expose the usefulness of the EHR, if the EHR could accommodate the needs of the physician, whether the EHR contributed to or detracted from patient care, and whether the EHR supported the goal of health information exchange. Knowing this will also help EHR vendors build better products. Opportunely, because EHRs already track what functionalities are used to perform tasks, EHR vendors should directly provide such information to CMS and ONC. This data capture mechanism also conveniently provides an audit trail for CMS.

Congress should work with ONC and CMS to implement a "record once, reuse multiple times" approach, leveraging EHR-captured data for multiple needs—including CMS's Promoting Interoperability programs and to inform EHR development going forward. To be clear, the intent is to reduce the reporting requirements on physicians by using EHR-captured data—provided by the EHR vendor—as an alternative, supplement, or direct replacement for physician reporting in programs like Promoting Interoperability. Ideally, EHR vendors would report on how a measure was achieved and physicians would attest (as discussed in the previous section) to their experience in meeting that measure. This not only reduces physician reporting burden, but also creates a feedback loop to EHR vendors—allowing them to improve EHR use based on physician need. The AMA strongly suggests Congress work with ONC and CMS to identify a plan to operationalize this concept. We offer our assistance in further reducing physician burden through this and other novel approaches.

ENCOURAGE COORDINATION WHEN DEVELOPING QUALITY MEASURES

Congress should encourage CMS and ONC to coordinate with health IT developers and measure stewards, including national medical societies, to ensure optimal development of electronic quality measures. Medical specialties should not be required to dilute measure development due to delinquencies in EHR data capture or reporting capabilities. EHR development continues to be shaped by Federal reporting requirements—not the needs of patients and physicians—which severely limits their ability to support actual patient care and improvement. Disconnecting the linkage between EHR development and Federal reporting requirements is also a crucial step in improving physician satisfaction.

Question. Are the proposed data blocking rules enough to start encouraging better data sharing by the vendors?

Answer. The proposed data blocking rules are one method to encourage data sharing. While the AMA supports several aspects of the proposed rules (*e.g.,* promoting patient access, certifying APIs, and removing EHR vendor gag clauses), ONC's and CMS's broad interpretation of legislative language, compressed development and adoption timelines, complex regulatory requirements, and a misplaced emphasis on data quantity will dramatically impact patient privacy and safety, data security, and further exacerbate physician burden and concerns with health IT. Without addressing these issues, the U.S. Department of Health and Human Services (HHS) may fail at meeting the goals set out by Congress in the 21st Century Cures Act (Cures).

PRIVACY

The problem: In the proposed rule, ONC did not indicate that it will create policy to help ensure patient privacy protections through the API. In other words, it is promoting API usage, but not requiring that the API technology include privacy and security controls. The technological capability to implement these controls exists, so if ONC doesn't implement controls, they are making a policy decision to not prioritize privacy. This is particularly concerning given ONC's information blocking proposal is more focused on requiring that data be shared.

Why this is important: Mobile apps typically require a consumer to consent to all terms or not use the app at all. However, we've all read stories and studies about

how smartphone apps share sensitive health information with third-parties, often without the knowledge of an individual.[6] If patients access their and their family's health data—some of which is likely sensitive—through a smartphone, a patient must have a clear understanding of the potential uses of that data by app developers. Most patients will not be aware of who has access to their medical information, how and why they received it, and how it is being used (for example, an app may collect or use information for its own purposes, such as an insurer using health information to limit/exclude coverage for certain services, or may sell information to clients such as to an employer or a landlord). The downstream consequences of data being used in this way may ultimately erode a patient's privacy and willingness to disclose information to his or her physician.

How Congress can address the issue: Congress could encourage ONC in the final rule to require an EHR vendor's API to check for these three "yes/no" adoption and implementation attestations as a part of the EHR vendor's certification requirements:

(1) *Industry-recognized development guidance* (*e.g.,* Xcertia's Privacy Guidelines);

(2) *Transparency statements and best practices* (*e.g.,* Mobile Health App Developers: FTC Best Practices and CARIN Alliance Code of Conduct); and

(3) *A model notice to patients* (*e.g.,* ONC's Model Privacy Notice).

These could be viewed as "value-add services" as proposed by ONC. The app could be acknowledged or listed by the health IT developer (*e.g.,* in an "app store," "verified app" list). EHR vendors could also publicize app developers' attestations. This shouldn't be a significant burden on EHR vendors since it's only requiring that an API check for an app developer's attestation. We also recognize this wouldn't ensure apps implement or conform to their attestations. However, we believe this will provide a needed level of assurance to patients and physicians, and would be greatly welcomed by users. CMS should require app developers to attest "yes" to each of these items before listing an app on its BlueButton 2.0 website.

PRESUMPTION OF GUILT WILL RESULT IN SIGNIFICANT PHYSICIAN BURDEN

The problem: Physicians may have a valid, reasonable reason to restrict the exchange of information. Yet ONC's interpretation of Cures creates an assumption that any physician who withholds data is guilty of information blocking. To counter this assumption and to justify withholding information for any reason, physicians must divert time and resources away from patient care to dissecting incredibly complex exceptions that are riddled with subjective terminology. Once a physician does so (potentially by hiring attorneys or consultants at great expense to the practice), he or she must create new policies and procedures, train staff, and adjust workflows. Furthermore, physicians may need to document the justification for applying those exceptions for every single request of information.

Why this is important: The inherent presumption of guilt, complex sub-exceptions, and substantial added burdens of ONC's proposal exceed the scope of Cures' intent. ONC should create policies that identify bad actors without placing considerable burden on the rest of the health-care system. Otherwise physicians will be tasked, time and time again, with the chore of documenting decisions that should be left to the physician's best judgement. Or, alternatively, they will just share whatever information they are asked for, regardless of whether the requestor has valid reasons for doing so, and the physician risks penalties for that, too. In either scenario, physicians and patients lose.

How Congress can address the issue: Congress can encourage ONC to clarify that a physician exercising his or her best judgement when providing information to a requestor will not be considered an information blocker. ONC should also remove

[6] Examples: (1) *The Wall Street Journal* reported that Facebook collected sensitive health and demographic data from a user's cellphone apps, regardless of whether the individual had the Facebook app on his or her phone, and even if the individual had never signed up for Facebook. (2) Studies reported in the *BMJ* and *JAMA* have demonstrated that most apps do not share privacy policies with patients, and when they do, sometimes do not adhere to them. (3) *The Washington Post* reported that a workplace wellness pregnancy-tracking app reports data to a woman's employer, including the woman's average age, number of children, and current trimester; the average time it took her to get pregnant; whether the pregnancy is high-risk, conceived after a stretch of infertility, a C-section or premature birth; and her return-to-work timing. The app's privacy notice is 6,000 words.

onerous requirements for physician to document their decision-making associated with qualifying for information blocking exceptions or sub-exceptions.

The AMA shares the administration's continued focus on improving interoperability and patient access across the U.S. Physicians and patients must be provided better access to needed clinical information while at the same time being assured privacy and security are strengthened. We look forward to continuing our work with Congress and administration to secure long-lasting revisions to health IT policy and implement the provisions in Cures.

Question. How can we encourage States to be better innovators on health-care spending? The current Medicaid waivers incentivize States to keep costs down, but are there ways to encourage both lower costs and better health-care outcomes?

Answer. MACRA was enacted almost 4 years ago, but most physicians still do not have opportunities to participate in APMs that meet the criteria for the bonus payments authorized by Congress. Congress authorized these payments not just as an incentive to participate in APMs, but because it recognized the time and costs physicians will face in transitioning to APMs. MACRA only authorized 6 years of APM bonus payments, and the current 2019 performance period is halfway through the available time to earn them. We urge Congress to extend this time period for more years so that physicians will have the opportunity to receive all of the support intended. Additionally, Congress can encourage APMs to control spending and improve quality in Medicaid by modifying the "all payer" requirement for a physician to become a qualified APM participant under MACRA. The rules for becoming qualified should encourage Medicaid and multi-payer APMs, but the current rules can actually discourage physicians from participating in Medicaid APMs because they would then need to meet an "all-payer" threshold of APM participation to qualify for the MACRA incentive payment.

QUESTIONS SUBMITTED BY HON. CATHERINE CORTEZ MASTO

Question. Nevada has one of the most significant health-care workforce shortages in the country. What kind of impact is MACRA having on the physician workforce? Are there ways to leverage the law to build that work force?

Answer. In order to prevent health-care workforce shortages around the country, the AMA has urged Congress to replace the upcoming physician payment freeze with annual positive payment updates over the next several years. MACRA included modest positive payment updates in the Medicare Physician Fee Schedule, but it left a 6-year gap from 2020—next year—through 2025 during which there are no updates at all. Following this 6-year freeze, the law specifies physician payment rate updates of 0.75 percent or 0.25 percent for physicians participating in APMs or MIPS, respectively. By contrast, other Medicare providers will continue to receive regular, more stable updates. As physician practice payments fall increasingly below their costs, patient access issues would arise. Rural health care will be more affected than other areas because increasing costs are spread across fewer patients, and many health-care employees can demand higher salaries that in urban areas where more applicants reside.

The recent "2019 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds" ("Medicare Trustees Report") found that scheduled physician payment amounts are not expected to keep pace with the average rate of physician cost increases, which are forecast to average 2.2 percent per year in the long range. The Medicare Trustees Report also found that "absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term." Therefore, to ensure the health-care workforce shortage does not increase and to provide physicians with a stable and sustainable revenue source that allows them a margin to invest in practice improvements and transition to more efficient models of care delivery, the AMA urges Congress to replace the upcoming physician pay freeze with annual positive payment updates.

MACRA included $20 million per year through 2020 to support the administration of technical assistance to help small and rural practices comply with the law's reporting requirements. Almost $35 million will be left as of this coming January, to remain available until expended.

Question. In your experience, has that assistance been helpful or successful?

Answer. While the AMA has strongly supported the provision of technical assistance to small and rural practices, and believes it is an important tool to make available to these physician groups, this technical assistance is not enough. Congress, CMS and the physician community must continue to work together to help small and rural practices succeed in the Quality Payment Program.

Question. Are practices aware of the availability of technical assistance? If not, what should we be doing to make them aware?

Answer. The AMA has worked with CMS to try and make physicians in all practices sizes and all specialties aware of the technical assistance that is offered by the agency.

Question. Looking forward, do you see that $35 million as sufficient to meet the needs of providers who are struggling to comply with MIPS?

Answer. The AMA encourages Congress to continue to fund technical assistance to help small and rural practices comply with the Quality Payment Program. In 2017, the national mean and median scores for all MIPS eligible clinicians were 74.01 and 88.97 points. However, the mean and median scores for small practices were 43.46 and 37.67. The lower scores achieved by small practices illustrate the need for Congress to work with the CMS and the physician community to continue to make changes that will help small practices and solo practitioners succeed in the program.

While continued technical assistance for small practices is important, the simplest way to ensure small and rural practices remain viable is to maintain the low volume threshold. To eliminate or reduce the threshold and force physicians to participate in MIPS would kill small practices. Financially, it just does not make sense for these practices with limited resources to invest in MACRA compliance when they have such a small Medicare patient population.

In addition, for those small practices that treat larger Medicare patient populations and participate in the MIPS program, the most helpful assistance comes in shaping the MIPS program to allow practices of all sizes to be successful. For example, the reduced reporting requirements for small practices in several of the MIPS reporting categories, hardship exemptions from the Promoting Interoperability performance category for qualifying small practices, or bonus points for small practices greatly help small practices succeed in MIPS.

Question. Are grantees able to use that technical assistance funding to help practitioners develop admissions to PTAC? If not, should we consider such authority? Should that be under the same program or developed as a separate program?

Answer. We agree more can be done to help physicians develop APM proposals. Having spent a year developing a proposal for PTAC, I can attest to the fact that the process is not easy and requires resources beyond the capability of most practices. Feedback from PTAC was very useful but PTAC was very concerned that it not overstep its limits, but more feedback would have been helpful. The AMA appreciated the Bipartisan Budget Act of 2018 provision that allowed the PTAC to provide initial feedback to proposal submitters. Unfortunately, the PTAC has indicated that it is still not able to provide technical assistance and data analyses to stakeholders who are developing proposals for its review. Additional technical corrections may be needed to provide the PTAC with more flexibility in this regard. In particular, the Bipartisan Budget Act of 2018 language stated that the PTAC can provide "initial feedback" on "proposals." HHS, which provides staff support to PTAC, has determined that this means no feedback can be provided until a complete proposal is submitted. In addition, HHS has determined that PTAC's feedback cannot involve "data or analyses whose only purpose is to aid further development of a proposal," "technical assistance in the development of the proposed model," or "instructions on how to remedy or fix any identified shortcoming(s)." (These prohibitions are stated on page 14 of the PTAC "Proposal Submission Instructions.")

Question. What portion of these providers do you think will never make it to an APM? Should we be concerned about that?

Answer. Physicians understand MACRA implementation is evolving and they are regularly reevaluating their participation options to determine which pathway best supports them in providing high value care to their patients. There are many variables that influence a physician's participation decision, and most notable is the availability of APMs and their readiness to move to financial risk. Risk is a major impediment for many practices, as by definition, risk implies that the results will not always be positive. Practices generally don't have reserves to pay for a year

where they must pay money back to CMS and they don't have the data analytic capabilities to determine how much risk they are taking on. For small practices, hiring a nurse educator to provide services for which there are no fees is a significant economic risk. To ensure a glide path to Advanced APMs, the AMA is urging Congress to extend the Advanced APM bonus payment to allow physicians a reasonable time period to transition to new payment models once they are made available. An APM should only put a physician at risk for the items they can control and never for so much risk that it could bankrupt the practice and destroy the infrastructure of care delivery.

Additionally, the best way to increase physician participation in APMs is to give physicians a major role in designing and implementing new payment models so the payments support the services physicians feel are necessary and accountability is focused on aspects of quality and cost that physicians can control.

Traditionally, APMs have been designed by payers in a top-down way. Physicians often feel that these models fail to provide the resources needed for high-value services or penalize them for delivering services their patients need. With the recent Primary Cares Initiative, CMMI is using proposals submitted to the PTAC by physicians to design its APMs and we welcome this change.

The AMA supports a bottom-up approach that starts by having physicians identify the opportunities to reduce spending through improving patient care and then designing APMs that will support the appropriate changes in care delivery.

Finally, many specialists simply do not fit into any of the current Advanced APMs. Often ACOs do not want to include them because their services are not needed frequently enough. Others have tried to develop models and submit them to PTAC, but CMS has not accepted them for further testing. There are signs now that CMS is more prepared to start testing PTAC recommended models, which is a very positive development. But this longer-than-expected ramp up period is why we are asking that the five percent incentive payments provided to early Advanced APM participants be extended in future legislation.

PREPARED STATEMENT OF FRANK OPELKA, M.D., FACS, MEDICAL DIRECTOR FOR QUALITY AND HEALTH POLICY, AMERICAN COLLEGE OF SURGEONS

The American College of Surgeons (ACS) thanks the Senate Finance Committee for convening a hearing on the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA). ACS has a longstanding commitment to improving the quality of surgical care and we are grateful to Congress for making quality a focus of the MACRA law. However, ACS has concerns that this focus may have been obscured as the priorities and ideas of Congress and the broader stakeholder community who partnered in developing MACRA met the constraints of a hurried implementation. We welcome the opportunity to continue partnering with Congress and the administration to ensure that the goal of improving the value of care to the surgical patient stays at the forefront.

ACS SUPPORTS THE CONGRESSIONAL INTENT OF MACRA BUT IMPLEMENTATION MISSES THE MARK

MACRA was intended to replace the failed cost containment strategy of the sustainable growth rate formula (SGR) by implementing payment incentives that rewarded physicians for improving quality and keeping down cost. In other words, the idea was to tie payment more closely to the value of care provided to the patient. Achieving this congressional intent in the area of surgery requires the establishment of a strategy for expressing what constitutes value in surgical care. This is not achievable using legacy Physician Quality Reporting System (PQRS) and Value-Based Payment Modifier (VM) measures. The Centers for Medicare and Medicaid Services (CMS) relied on their skills as a payer to retrofit their payment models with sporadic, disaggregated quality metrics. The end result has been disruption of the care teams and a disconnect from real quality of care. For many physicians, the Merit-based Incentive Payment System (MIPS) has not, and given its current trajectory will not, serve as a driver of improvement in quality or reduction of cost.

In addition to these implementation issues, we also have great concerns about the structure of payments under MACRA in the years ahead. The modest statutory updates included in the law are now finished, and we will soon enter a 6-year period with no updates. This will likely result in real reductions to payments due to inflation and budget neutrality requirements. Additional incentives for high performers

and qualified Alternative Payment Model (APM) participants also disappear during this time, which will be experienced as reductions by many of the highest performing physicians in Medicare. While the focus of the testimony today is improving incentives for quality and value, the ACS urges Congress to consider these factors as well. The ACS would welcome the opportunity to further describe the physician payment landscape from our perspective and how this might affect access to care in the future.

QUALITY MEASUREMENT IN MIPS AND APMS

ACS Vision for Meaningful Measurement Models

ACS continues to welcome and celebrate the congressional focus on quality and value built into MACRA, including the concept of rewarding those who provide high-quality surgical care while holding down costs. However, CMS as a payer does not have the resources or knowledge to generate the master plan for quality for a surgical team working toward a patient outcome in a particular episode of surgical care and therefore must first fully collaborate with the surgical community. This collaboration would include (1) defining the patient-centered care model, (2) identifying the structure and processes required to deliver quality in surgical care, and (3) assigning quality metrics and attaching an incentive payment program to achieve care goals.

Expressing value in surgical care requires appreciation of the specific condition and its care model, consideration for clinicians and their unique roles as team members in providing surgical care to the patient, and the ultimate outcome of that care. With this understanding, it is possible to define the critical data and measurement elements across the care model for the team, which is essential in driving improvement. What follows then is agnostic to the payment system; it is possible for CMS to use the various tools of MACRA to design a payment model either within Medicare fee-for-service (FFS) or within some form of APM.

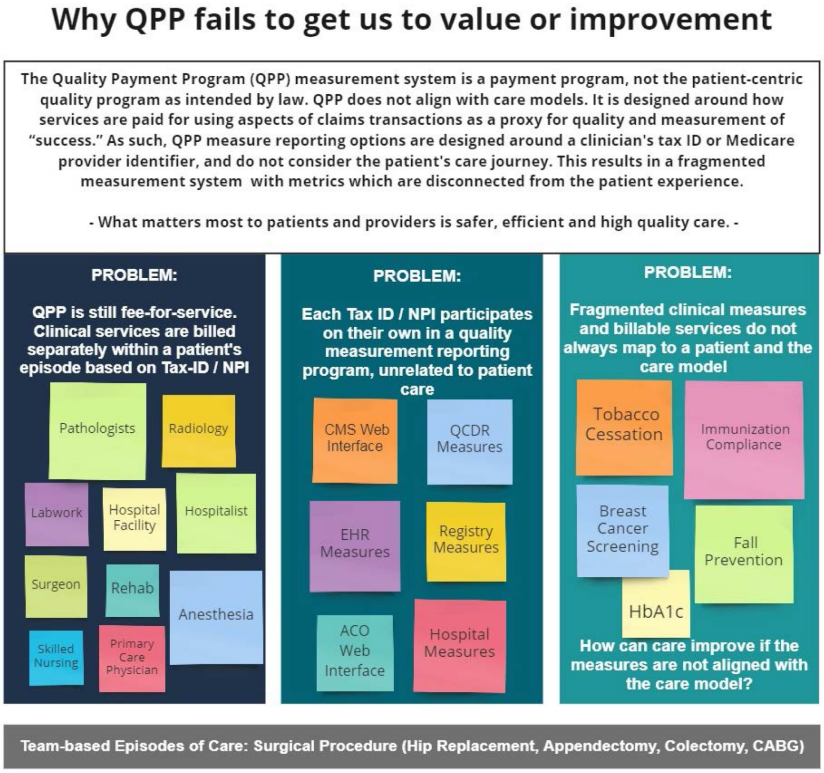
More specifically, by designing a master quality care plan for surgical care as the first step, these value-based models can be tailored to a broad range of payment models such as FFS in MIPS, Accountable Care Organizations (ACOs), bundled payments such as the Bundled Payment for Care Improvement—Advanced (BPCI–A) model, or other APMs. This master quality care plan would be used to measure quality across all payment programs so that the care team has one valid and meaningful quality target to define value for surgical care. Such an effort will also greatly reduce burden.

The ACS developed a model formula that could serve as the foundation for quality in surgical care. The ACS model formula for expressing value in care does not differ from those found in other industries. ACS believes that quality of care begins by setting evidence-based standards for care, ensuring that the right infrastructure and systems are in place through measurement and verification, and incorporating data at the point of care to inform surgeons' and patients' decisions. The patient should have a voice to determine whether the treatment met his/her goals. We define the episodes for a given domain such as trauma care, cancer care, or complex gastrointestinal care as examples and assign a surgeon champion. Within each of these domains, evidence-based, common standards are applied for areas that affect all surgical patients. Specific standards can also be applied for each individual surgical episode or condition. With the proper standards, infrastructure, data, and verification we can greatly improve outcomes and patient safety while simultaneously reducing complications and other unnecessary costs. If implemented correctly, the data generated helps to feed research into which interventions and care are most effective, creating a beneficial cycle of quality improvement. This marriage of quality and cost for a given treatment, condition, or episode of care is a true representation of value.

QPP Incentivizes Check-the-Box Compliance Instead of Striving for Quality Improvement

An increasing number of surgeons recognize that CMS efforts are not contributing to higher quality surgical care. The rational response is for surgeons and/or health care administrators to simplify their engagement in MIPS by taking the necessary steps to assure payment rather than to focus on quality. The figure below illustrates that the Quality Payment Program (QPP) is designed around how services are paid for, using aspects of claims transaction as a proxy for quality and measurement of "success," at the level of the tax identification number (TIN). The current measurement system does not consider the patient's care journey and does not represent a patient's experience. For example, an ever-greater percent of surgeons are partici-

pating in quality reporting through the CMS Web Interface group reporting option. This translates into reports based on large groups of physicians (frequently providing care for very different patients and conditions) gathered under one TIN. It does not translate down to the care a surgical patient receives. In other words, surgeons receive credit for how well their group immunizes a population instead of assuring patients have safe surgical care.



Currently, much QPP reporting takes place in the CMS Web Interface option, which allows groups of at least 25 eligible clinicians with the same TIN or participants in certain ACOs to submit data together and be measured as a single unit. The Web Interface is a stable, known program to administrators. They know what their scores are likely to be, and it is built into the workflow for their organization. While easy for physicians to comply with, the ten measures available in the Web Interface are focused on screening, preventive care, and diabetes control. These measures are important to a patient's overall health but provide absolutely no information on the quality of surgical care received by patients of surgeons in these groups and therefore are not relevant to efforts to improve surgical quality.

MIPS participants can choose to report both as part of a group and as an individual, but the majority of surgeons are unlikely or unable to do so due to financial implications. Administrators and the C-Suite often decide the most cost-effective way for the TIN to report in MIPS, and specialty specific reporting may result in a lower MIPS score. In fact, performance data from the first year of MIPS shows that the median score of groups was more than 50 percent higher than that of those who participated as individuals. For clinicians who still choose to report specialty-specific measures, those available are not patient focused, frequently dating back to the PQRS program, and are designed for an exclusively FFS world. Furthermore, new measures without a benchmark can only receive the lowest amount of points. These problems stem from how CMS has set up reporting incentives, favoring large group reporting on primary care.

Many believed that Qualified Clinical Data Registries (QCDRs) which are referenced more than 20 times in MACRA, would be a key pathway for stakeholders to influence quality measures. However, roadblocks emerged that impeded the ability of specialty societies to measure quality based on what matters most to their patients. There is a huge disincentive to use QCDRs for many specialties, such as the constant annual removal of measures, and very low opportunities for earning points. New measures without a benchmark receive the lowest point value. This has greatly limited the value and uptake of these registries.

Data rigor and aggregation standards are also crucial to registry success. As a payer, CMS has little ability and expertise to utilize these registry elements and value these tools within their current measurement systems, resulting in a cacophony of reports that are meaningless to the end user. Only when registries have standardized data, aggregation, normalization, and reporting from a single source of truth are they of value. This is evident in registries maintained by ACS. Registries and the information they provide are best implemented within an overall care plan where a team of experts use the knowledge imparted to inform the patients and the team members about clinical care based on rigorous data. The ACS continues to work to demonstrate how to structure data models for care improvement.

In sum, CMS's implementation of MACRA has fostered a payment model rather than first focusing on quality. As a result, surgeons currently lack confidence in CMS as a source of quality reporting. Thus, we expect more surgeons will be reporting through the group reporting options, which constitutes the path of least resistance. This is unfortunate since it may have the additional consequence of crowding out other efforts aimed at improving quality in surgical care and areas that are not incentivized. It also seems counter to the intent of MACRA which encouraged CMS to seek comprehensive measurement of groups. The statute notes that to the extent practicable, group measurement should reflect the range of items and services furnished by the eligible clinicians in the group. This is not currently the reality in the CMS Web Interface.

A Way Forward in the QPP: Proposed ACS Measurement Framework for Value-Based Care

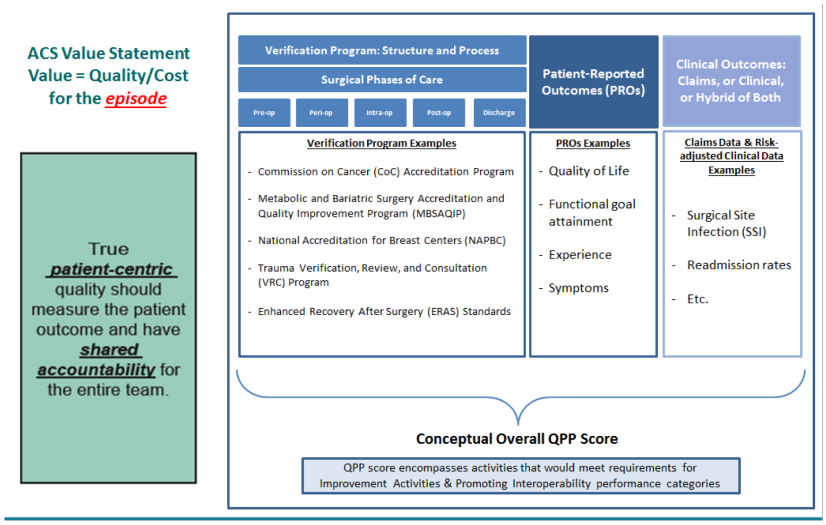
The ACS proposes alternate quality measurement structures for the QPP based on our more than a century of experience in surgical quality improvement. This focus on quality resulted in the publication in 2017 of "Optimal Resources for Surgical Quality and Safety," referred to as the Red Book. This comprehensive volume serves as a manual for those seeking to build a learning environment designed to provide patient-centered, high-quality care. Standards drawn from the Red Book are now being used for the verification and accreditation of hospitals on the basis of surgical quality and patient safety.

The ACS alternative framework for surgical quality measurement is comprised of three components:

1. *Verification of Key Standards of Care:* Since the inception of the ACS, we have sought to build standards for clinical domains with the expectation to improve overall outcomes of surgical care. While implementing these standards, we have gained over a half-century of experience in building clinical verification programs in specific clinical domains to drive quality, improvement, and excellence in care. The success of verification programs are well-established in the peer-reviewed literature. Each of the major surgical domains contain a set of standards for inclusion in a renewable, triennial verification program. The long-term goal is to scale these verification programs initially through pilot testing, then as a foundational component to building a national quality system in surgical care.
2. *Clinical Outcome Measures:* We envision the use of administrative claims measures for surgical procedures that have a low event rate of care for poor outcomes (readmissions, mortality, reoperation, etc.), and propose using programs such as the National Surgical Quality Improvement Program (NSQIP), for complex, high risk care that have variation in outcomes and require risk adjusted, clinical outcome measurement with a high level of rigor. This would require pilot testing before large-scale implementation.
3. *Patient-Reported Outcomes:* In addition to standards-based verification programs and clinical outcome measures, we propose inclusion of patient-reported outcomes measures (PROMs) based on an episode of care. Episode-based PROMs are inclusive of the patient's voice and can assess whether

care achieves the patient's goals, including functional outcomes and quality of life. We have begun early testing and development of enriched PROMs, focused on surgical outcomes. This model is designed to recognize the complexity of modern medicine and demonstrate that it exceeds the ability of a single physician to provide all of the care.

This framework, which is illustrated in the figure below, is based on decades of research and implementation of verification programs, which have proven successful in driving better outcomes in surgical care. It is applicable across various clinical domains, particularly in surgery where robust verification programs exist in areas such as cancer care, trauma care, bariatric care, and care for frail geriatric patients. Such programs depend on triennial surveys, and already exist in thousands of delivery systems today with demonstrated success. As an example, measurement of cancer care spans the entire care journey experienced by patients and includes areas such as prevention, screening, early diagnosis, treatment, post treatment surveillance, and end-of-life care. A surgical resection for cancer may involve debulking and staging the disease, while also including a method for tracking quality through verification of key standards, PROMs, and clinical outcomes. Furthermore, if such a quality framework were combined with the ongoing cost measurement work that formed the core of the ACS–Brandeis Advanced APM described below, then this would constitute quality and cost measurement across standardized episodes of care representing true value to the patient.



PTAC RECOMMENDATIONS TO PILOT APMS NOT ACTUALIZED

In addition to MIPS, MACRA created a separate option for participation through APMs. Since quality measurement in APMs is required only to be "comparable" to that in MIPS, APMs were considered an attractive option to propose innovative measures and new concepts. The inclusion of the Physician-focused Payment Model Technical Advisory Committee (PTAC) in MACRA was seen by many in the physician community as a positive step. MACRA payment incentives and the establishment of PTAC encouraged the development of physician led models, creating a clear pathway for the transition from FFS to APMs.

ACS recognized the importance of the value transformation in healthcare through APMs and partnered with experts in episode-based cost measurement at Brandeis University to develop the first proposal received, evaluated, and ultimately recommended by the PTAC in April 2017. The ACS–Brandeis Advanced APM proposal incorporated cutting edge cost and quality measurement beyond that currently required by CMS in the FFS world into a new value expression. The PTAC thoroughly vetted the model both through written requests for information and at an in-person meeting. PTAC ultimately agreed that the proposal satisfied their quality criteria. Unfortunately, the ACS model and many other models recommended for testing or

implementation in the QPP have not been acted upon, closing another door for truly meaningful quality measurement.

SUMMARY

MACRA promotes innovative quality and cost measures as well as the development of alternative payment models. We welcomed the legislative intent to improve care and have been hopeful the implementation of the law would promote meaningful surgical quality over the burdensome, insignificant measures used in many of the previous payment programs. Without real meaningful quality measurement, MACRA will fall short of achieving the aspirations of patient-centered quality care. The QPP as it currently stands fails to provide meaningful quality measurement and is in need of a course correction.

ACS holds that what matters most to patients and providers is safer, more efficient, and higher-quality care. It is with these goals in mind that we designed our proposed measurement framework for value-based surgical care. Congress should encourage CMS to partner with clinical stakeholders to evaluate and test innovative, evidence-based proposals such as the one we have described. We believe CMS has the authority to accomplish this but may benefit from additional guidance from Congress. CMS may require additional resources to increase their ability to accept meaningful data and administer the QPP in a way that supplies participants with the tools and data they need to improve value, and patients with the information they need to make the best possible choices for their care. Creation of a formal process for partnerships with the physician community on efforts to improve value for patients could help improve the quality of care for Medicare patients and truly refocus the incentives in MIPS toward higher value care. This would go a long way toward ensuring the long-term viability and success of the QPP and MACRA.

QUESTIONS SUBMITTED FOR THE RECORD TO FRANK OPELKA, M.D., FACS

QUESTIONS SUBMITTED BY HON. ROB PORTMAN

Question. I introduced the Medicare Care Coordination Improvement Act with Senator Bennet in an effort to reduce some of the barriers that providers face when they participate in alternative payment models. However, one particular section of my bill focuses on providing temporary waivers to practices that are interested in testing their own APMs. HHS has been slow to take up new APM concepts, and thus: what can we do to incentivize the establishment of new APMs? Has the PTAC offered a viable way to propose and test new APMs? If not, what actions could be taken to encourage the adoption of PTAC models?

Answer. The American College of Surgeons (ACS) thanks Senator Portman for the opportunity to provide feedback on ways to incentivize new Alternative Payment Model (APM) development. The ACS is supportive of the Medicare Care Coordination Improvement Act, as it will likely help to spur more APM development. However, it is imperative that CMS has the tools and commitment to implement new and innovative payment models.

Because quality measurement in APMs is required only to be "comparable" to that in the Merit-based Incentive Payment System (MIPS), APMs were considered an attractive option to propose innovative measures and new concepts. The inclusion of the Physician-focused Payment Model Technical Advisory Committee (PTAC) in Medicare Access and CHIP Reauthorization Act (MACRA) was seen by many in the physician community as a positive step. MACRA payment incentives and the establishment of PTAC encouraged the development of physician led models, creating a clear pathway for the transition from fee-for-service (FFS) to APMs.

ACS recognized the importance of the value transformation in health care through APMs and partnered with experts in episode-based cost measurement at Brandeis University to develop the first proposal received, evaluated, and ultimately recommended by the PTAC in April 2017. The ACS–Brandeis Advanced APM proposal incorporated cutting edge cost and quality measurement—beyond that currently required by CMS in the FFS world—into a new value expression. The PTAC thoroughly vetted the model both through written requests for information and at an in-person meeting. PTAC ultimately agreed that the proposal satisfied their quality criteria. Unfortunately, the ACS model and many other models recommended for testing or implementation in the Quality Payment Program (QPP) have not been acted upon, closing another door for truly meaningful quality measurement.

Question. Per data from CMS, about half of all Medicare providers are participating in MIPS, with the majority of these non-participating providers being exempt via the low-volume threshold. While we don't want to place additional burdens on small and rural providers, we should be identifying ways to engage with these practices to help them transition towards value-based outcomes.

What actions should be taken to engage with these providers?

Answer. The ACS shares your concern for small and rural physicians, but believes it is fortunate that they are currently exempted from MIPS. Until there are meaningful measures, these physicians should remain focused on properly treating patients rather than complying with burdensome meaningless activities.

QUESTIONS SUBMITTED BY HON. RON WYDEN

Question. As I mentioned during the hearing, I often hear from seniors in Oregon that they don't feel like anyone is in charge of managing their health care and helping them navigate the health-care system. I am proud of the bipartisan work that this committee did on the CHRONIC Care Act last Congress to update the Medicare guarantee. In my view, the next step should be making sure that all Medicare beneficiaries with chronic illnesses have someone running point on their health care—in other words, a chronic care point guard—regardless of whether they get their care through Medicare Advantage (MA), an accountable care organization (ACO) or other alternative payment model, or traditional fee-for-service Medicare.

For beneficiaries in traditional fee-for-service Medicare, what can be done to improve care coordination and make sure their physicians and other health-care professionals are all talking to each other and working together to provide the best possible care to those beneficiaries? What specific policies would you recommend this committee pursue toward that end?

Please describe the specific steps that Congress and/or CMS could take to ensure all Medicare beneficiaries with chronic illnesses, including those in traditional fee-for-service Medicare, have a chronic care point guard.

Answer. The ACS thanks Senator Wyden for the opportunity to provide feedback on improving care coordination for patients with chronic illnesses. The ACS represents surgeons and their patients, many of whom are faced with chronic conditions which tend to complicate their surgical care. It is important that the Congress and the Centers for Medicare and Medicaid Services (CMS) begin to recognize that the health-care sector is no longer represented by cottage industries in a simple transactional business, with one stop shopping for care. Instead, the current system utilizes a continuum of care which is extraordinarily complex. Modern care models have advanced to team-based care with the patient in the center.

The ACS understands the concerns of Senator Wyden's constituents regarding their need for a "point guard." This analogy is quite fitting. The point guard is an active participant as well as the in-the-game coach guiding her team. Modern day treatments are too complex for any one physician or surgeon to assume all responsibility for optimal care. Care occurs in teams of clinicians working together to optimize the outcome and meet the goals of the patients.

Yet, the actions of fee-for-service and CMS have been detrimental to the modern-day care models. No point guard operates alone or can win the game by herself. It takes all of the team members working in concert to accomplish the complex outcomes patients seek. While the care models have advanced to team-based care, with the patient in the center, the business models and payment models are lagging. Physicians are still competing to be the source of care which is paid, rather than optimally serving the patients as a team. The over-emphasis on one member of the team and not on the entire team is detrimental to the overall goal. If the only member of the team is the point guard, what would you expect the reaction to be from all the other team members who are so essential in assuring the best outcome?

Everyone has a role to play and everyone is essential to lift up all their teammates in their roles. As exuberance builds for the point guards, let us not forget how to build the entire team toward the excellence in outcomes we seek.

In order to make this actionable, there are several aspects of modern care which need to be rewired in order to create sustainable transformation of care. First, the most important focus has to move from payment models and an electronic health record (EHR) focus to center attention on the actual care model. *Care models* are

now team-based care models with the point guards as primary care physicians (PCPs) coordinating with patients and a broad array of specialty medicine, including surgeons. Operationalizing the care models are *business models* which refer to how clinical practices pull together the essential resources to optimal practice (staff, equipment, information services, inter office communication, finance etc.). Once the care model and business models have taken shape, the practice revenue models or *payment models* have to match the care model with a payment model. Some conditions are self-limited, with brief care models which may be simply managed by one physician, the care model will be narrow and brief making fee for service a rational choice. Other aspects of care are far more complex and require team-based revenue models. Payers need to think about how to ultimately drive the best care models and resources for business models in rethinking payment and not simply tweak around the edges of fee-for-service.

Beyond these three aspects of care models, business models and payment models are the actual physician *compensation models.* Physicians are primarily compensated based on relative work units and not on how patients feel about achieving their outcomes making it rational for a physician to drive toward more work units for compensation. This is driving volume of services to higher levels and not always for the right reason. In order to move away from volume-based payment, compensation plans need to become linked to value, and be designed with team-based care in mind.

In order to achieve the goals of care coordination, more needs to be done to ensure that digital health information services are not heavily siloed by EHRs. Patients not uncommonly have different parts of their health in different EHRs. So their health information becomes siloed. To move towards breaking down silos, Congress should envision a *digital information health system as a service to patients, Software as a Service (SaaS).* This can be achieved by building an open standard, patient cloud and requiring every EHR to conform to providing data to clouds which conform to the standard. By doing so, this will ensure that patients, point guards (PCPs), and all other medical specialties are able to see the entire patient record and not just one site's EHR view of a patient. Patients' data live in more than one EHR and more than EHRs can talk to clouds in today's world of the Internet of Things (IoT). To fully enable the care model, the business model, the payment and compensation model, and to create a complete team for accountability requires a digital ecosystem well beyond the constraints of an EHR. This ecosystem is struggling to emerge because of the constraints by EHR vendors, by an over emphasis of EHR solutions rather than cloud solutions, and by the lack of a personal medical identification number which is essential for creating a unique patient record in the cloud. The care patients would receive for having such an open source cloud architecture would take digital health services to a new level. Congress needs to reduce the complexity surrounding digital health services and expand the opportunity by empowering Federal agencies to work collaboratively within the government and with the private sector.

Question. Eligible clinicians who receive a certain percentage of their payments or see a certain percentage of their patients through Advanced APMs are excluded from MIPS and qualify for the 5-percent incentive payment for payment years 2019 through 2024. Starting this year (performance year 2019), eligible clinicians may also become qualifying APM participants (and thus qualify for incentive payments in 2021) based in part on participation in Other Payer Advanced APMs developed by non-Medicare payers, such as private insurers, including Medicare Advantage plans, or State Medicaid programs.

Recognizing that this is the first year in which the All-Payer Combination Option is available, how many of your members do you anticipate will take advantage of the All-Payer Combination Option this year?

What, if any, challenges have your members faced when attempting to take advantage of the All-Payer Combination Option?

Answer. We appreciate the Congress's efforts to expand eligibility for inclusion in incentives for payment through the Advanced APM (A–APM) and recognizing All-Payer Combination options. Our members are divided into two broad classes when thinking of payment in A–APMs. One group includes our employed surgeons and the other group includes the self-employed surgeons. The employed surgeons are typically part of larger contract groups and are pulled into commercial models based on enterprise contracting. The self-employed surgeons struggle more with complex risk-based contracting and would prefer to remain in fee-for-service MIPS programs. The self-employed are smaller group practices which lack the ability to assume

much in terms of risk, do not have the data infrastructure for risk based contracting, and cannot manage risk in general.

In addition, the current CMS implementations for A–APMs are typically payment models based on fee-for-service, but are not necessarily built on a care model. As such, care remains fragmented even while in bundles which contain fragments of fees for various services provided. If the intent of MACRA is to truly focus on improving quality and reducing costly waste by using risk-based payment models to affect real change, consideration has to begin with building care models which are suited for all types of patients, their conditions, and a broad array of practice types. Thoughtful design of APMs requires input from the physician community in order to appreciate the interrelationships of how care is delivered. This will require a means for bringing teams together for patient care, with shared risks through aligned incentives, openly shared common data dashboards. This will need to be consumable by small group practices in rural America as well as in large delivery systems.

For now, all-payer activities are not standardized, with each payer creating their own iteration of the various aspects of an APM. This creates chaos at the point of care. It is difficult for a team of clinicians to understand the nuances of various payment models between insurers, when the real focus should be on a patient. For the government to promote all-payer models, first we need the government to realize all the aspects of care and business practices which need to be standardized.

Just imagine a single procedure such as a lung resection or a cardiac bypass. If ten payers each had their own prior authorization rules, their own data elements, variation in their applications of risk based contracting, and different quality metrics, then these ten payers multiplied by four sets of variables would create forty variables; which are too burdensome for a system to manage. This is for only one procedure and it has already reached the level of being an unmanageable burden. Ultimately, surgeons would end up chasing after payment rules and differences between payers rather than clinical care, with a significant impact on both patients and surgeons.

QUESTION SUBMITTED BY HON. DEBBIE STABENOW

Question. I am very proud of the work the bipartisan accomplishments to address Alzheimer's, including the implementation of my HOPE for Alzheimer's Act which required Medicare to pay for new individual care plans to support Alzheimer's patients and their families. Many of my colleagues are also cosponsors of my Improving HOPE for Alzheimer's Act, which will ensure beneficiaries and physicians know that they are able to access, and bill for, care planning under Medicare. In our last hearing on MACRA implementation, my colleagues raised the question of how we should look at quality measures in MIPS when it comes to physicians having these conversations with beneficiaries and their families and reflecting their priorities. Some have mentioned altering MIPS to make the quality measures more clinically meaningful. In what ways do you think the system would need to change to better incorporate long-term care planning and encourage physicians to have these conversations with patients?

Answer. The American College of Surgeons (ACS) thanks Senator Stabenow for the opportunity to provide feedback on meaningful quality measurement under the MIPs program. While most surgeons do not engage in long-term care planning, the ACS maintains that CMS should work with stakeholders to develop measures that are more meaningful to providers, with the goal of improving the value of care.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

THE PATIENT VOICE IN MACRA

Question. In your testimony, you mention the importance of patient-reported outcomes. I agree that we should be measuring whether or not we are paying for care that is in line with the patient's goals. During the hearing I asked you how many of the 424 MIPS measures consider the patient voice and their priorities. You told me that zero of the surgical measures in the payment program are patient reported outcomes.

What more can your physician organization do to ensure patient needs and priorities are kept at the center of health-care delivery?

What more can and should CMS and Congress do to ensure patient needs and priorities are kept at the center of health-care delivery?

Answer. The American College of Surgeons (ACS) thanks Senator Brown for the opportunity to provide feedback related to the inclusion of patient needs and priorities in care delivery. Ensuring patient needs and priorities are communicated and met is especially critical in the delivery of surgical care because most surgical procedures are elective and performed with the goal of improving a patient's well-being. Therefore patient reported outcomes (PROs) are the best determinant of whether an operation was successful. Some examples of PROs include measurement of functional goal attainment, severity of symptoms, quality of life, etc.

To be inclusive of the patient's voice, we have to move away from collecting patient reported data in the form of long surveys administered after a hospital stay or procedure, such as the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys (currently part of the MIPS program). These retrospective PROs do not provide an opportunity to address patient needs during their care journey.

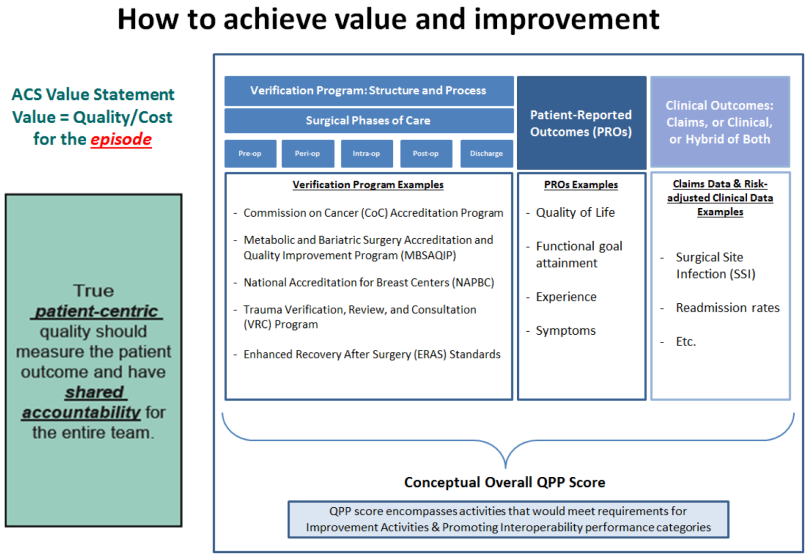
We believe that the integration of the patient experiences and milestones within the clinician workflow, including the collection of PROs in more frequent, but brief, occurrences throughout their episode of care, can provide meaningful information to physicians. Information such as progress on care goals, post-surgical recovery, pain management, and rehab and therapy are critical to ensuring meaningful care delivery. This will enable a more patient-centric approach to surgery while facilitating shared decision making and increased communication with the patient and surgical team.

To scale PROs nationally, patient portals and third-party applications connected to EHRs through application programming interfaces (APIs) could create additional options for the patient's voice become a part of clinical decision-making. This would create a simple interface for users to respond to questions and share data back to their physicians. There is a great opportunity through the implementation of 21st Century Cures to leverage technology to achieve these goals.

In the short term, CMS should leverage current resources to prioritize outcomes that matter to patients with the use of the PROs to receive frequent patient feedback across a patient's care journey, as described above. One immediate action CMS should take is to immediately distribute the funding available through the MACRA Measurement Development for the QPP to develop, test, and implement PROs to measure care across the care continuum fit for value-based payment models.

In the longer term, we urge CMS to build a value framework based on what matters most to patients—safer, efficient and high-quality care. To do so, payers need to think about how to ultimately drive the best care models and resources for business models instead of designing quality measures based on fee-for-service transactions without measures that map to the care a patient experiences. True patient-centric quality should measure the patient outcome and have shared accountability for the entire team while ensuring the appropriate resources and risk-adjusted clinical data are available for quality improvement and patient safety. Below is a figure that details how to achieve patient-centric value and improvement across an episode of care by the use of:

1. Verification of key standards of care (such as the ACS trauma verification program).
2. Patient-reported outcome measures.
3. Clinical outcome measures.



This framework is based on decades of research and implementation in verification programs, which have proven successful in driving better surgical outcomes, and is supported by over 2,000 publications in the literature. The proposed framework includes patient-reported outcomes, which will need to be tested. Our proposal is based on the simple tenet that patient-centric quality should measure the patient outcome and incorporate shared accountability for the entire team.

This model relies on validation of successes by measuring outcomes using clinical data analytics, which partially depend on bi-directional automated interoperability for data exchanges to and from registries. Our proposal is simultaneously integrated into surgical workflows, while reducing burden by measuring compliance with standards through triennial surveys, rather than measures linked to CPT or diagnosis-related group (DRG) codes. Such surveys exist in thousands of delivery systems today, with demonstrated success in trauma, cancer, and bariatric surgery.

DEVELOPMENT OF METRICS IN MACRA

Question. I have heard from a number of physicians who believe that there is no link between many of the MIPS measures they are required to report and improving clinical care for their patients. I understand that the physician community has engaged with CMS to try and make the program more meaningful to physicians and patients through more relevant quality measures.

How are clinicians from your organization involved the creation of these measures relevant to their specialties?

Has CMS been receptive to your feedback when provided?

How would you assess CMS's collaboration on achieving meaningful metrics?

Are there any changes in this process you would recommend?

Answer. *A Majority of Surgeons Are Measured for Complying With Primary Care Measures:* We do not believe that CMS has been receptive to our feedback because the majority of surgical care is not measured in the QPP. The program uses metrics broadly applied across physicians without a real appreciation for the details involved in surgical quality and improvement, despite suggestions from ACS and other specialties to design the program as such. Instead, most surgeons required to participate in the QPP are ranked based on measures in the CMS Web Interface or the Accountable Care Organization (ACO) Web Interface, which evaluate large group practices' compliance with primary care services, such as immunizations, blood pressure control, diabetes control, and tobacco cessation. These measures do

not provide the information surgeons need to improve care, including critical patient safety indicators, or information patients seek when looking for a surgeon. Instead, compliance with these measures leads to added administrative burden and detracts resources away from highly successful quality improvement programs.

This is a result of CMS developing the MIPS measure framework based on clinical services billed to Medicare based on a surgeon's TIN, not episodes of care. The measures are reported using a submission process that does not consider the care delivery model. The result is fragmented metrics that do not always map to the patient and the care model, as illustrated below:



CMS Does Not Value Conformance With Key Process Measures: Since the inception of the ACS, we have built standards for clinical domains with the expectation of improving overall outcomes of surgical care. Through this work, we have gained over a half-century of experience in building clinical verification programs for specific clinical domains. Each of the major surgical domains contains a set of standards as part of a renewable, triennial verification program. These programs have proven to drive quality, improvement, and excellence in care. Compliance with ACS verified standards (such as the ACS Trauma verification program) confirm appropriate structure and resources are in place for optimal care.

However, the CMS "topped out" measure policy devalues these critical process measures by removing measures with a high performance rate. An example of a process measure that CMS has determined is topped out and plans to phase out of the program is use of the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) Surgical Risk Calculator measure. CMS policy does not value this measure, but the College maintains that every patient undergoing an operation should have access to a risk calculator that predicts the likelihood of a positive outcome. This step in preoperative planning provides an opportunity for the surgeon and the patient to engage in shared decision making, including whether an operation is the ideal form of treatment. Shared decision making does not occur commonly enough, but most patients consider it an essential part of care planning.

CMS Is Reluctant to Test Innovative Physician-developed Models: MACRA payment policies and the establishment of Physician-focused Payment Model Technical Advisory Committee (PTAC) clearly incentivize the development of, and participa-

tion in, Alternative Payment Models (APMs). ACS and others have recognized the value of creating such models and have expended significant time, effort, and resources in doing so. The ACS–Brandeis Advanced Alternative Payment Model (A–APM), which was recommended by the PTAC but not implemented, would allow for the use of episode-based surgical measures meaningful to surgeons and surgical patients. The health-care community has rallied to meet Congress's challenge to develop new physician-focused models but the disconnect between the PTAC recommendation process and the testing of new models by CMS poses a significant barrier to innovation. Instead of testing new models developed by physicians, we continue to see variations on existing CMS models such as the Bundled Payments for Care Improvement (BPCI) Advanced or the ACO Track 1+. While we believe there is great merit in the move toward A–APMs and plan to continue work on developing core concepts of the ACS-Brandeis A–APM, it is unfortunate that the input from the broader health-care community has not led to the implementation of physician-built APMs by CMS.

Additionally, MACRA allocated $15 million a year for 5 years starting in 2015 to incentivize the development of innovative quality measures. This money has been slow to flow to new measure development. This money was intended to be used to help fill gaps where measures fail to meaningfully measure care delivery, including surgical PROs. ACS submitted a proposal to CMS fund the development of a value-based measurement framework to measure surgical care, but funding was not granted.

QUESTIONS SUBMITTED BY HON. SHELDON WHITEHOUSE

Question. Accountable Care Organizations (ACOs) have the potential to transform our health care delivery system. While we've seen ACOs improve patient care and create shared savings, many provider-led ACOs only control a small fraction of total spending, with specialists, pharmaceuticals, and hospitals accounting for most of it. This leads to ACOs lacking sufficient leverage to bring down costs and can contribute to shared losses.

How can we improve the ACO model to account for this imbalance? How can we support successful ACOs and encourage more providers to follow their lead?

Answer. The American College of Surgeons (ACS) thanks Senator Whitehouse for the opportunity to provide feedback on ways to improve Accountable Care Organization (ACO) models. The early wins in ACOs have come from the "low-hanging fruit" typically found in pharmacy costs, site of service differentials, excessive imaging usage, and excessive visits for patients with chronic conditions. These are common, recurring costs which are easily controlled by simple cost saving efforts.

Taking ACOs to another level with the goal of transforming care, with the addition of medical specialties to the action plan, will involve a major redesign of care. Much has been made of primary care as the major source of savings without realizing the complexity of care today far exceeds the single-transactional mind-set of past care delivery. The science of medicine has outstripped the ability of a cottage industry for a single professional to remain current and practice the best care once the care required becomes complex. Modern care models have advanced to team-based care with the patient in the center. While basics in prevention and maintenance of care are still delivered between a patient and their doctor, once care becomes more complex, it takes a team to deliver the type of care needed to stay ahead of a condition or disease.

Currently, most specialty-based medicine continues to be incented by fee-for-service revenues and volume-based compensation. To change their direction means taking steps to redesign the care models and their associated underlying business models. Underneath the care models and business models are needed complex data infrastructure to inform the entire care team of a patient's journey. These remain fragmented and difficult to manage in an ACO. Fee-for-service revenue models and compensation plans for physicians still predominate medical specialties even within ACOs. The infrastructure to craft the sort of change needed is taking shape but needs directional guidance and incentives from the government in order to accelerate the change for true health-care transformation. Total cost of care (TCOC) for an episode would provide patients and their medical teams the ability to understand the price of the medical goods and services incurred by patients and payers. However, if each payer performs their own cost of care model, the impact for patients and clinicians will be chaotic. A single standard is needed to apply all-payer claims

data and determine the standard method for providing costs. The ACS has worked with the Centers for Medicare and Medicaid Services (CMS) to promote the CMS Episode Grouper Methodology and through our work with Remedy Health, Cerner, and Brandeis University, we have stepped up to create a TCOC system as a public utility for all to use in a new non-profit entity referred to as PACES—the Patient-Centered Episode System.

The unit of analysis of specialty medicine, particularly surgical care, should expand to consider team-based episodes of care. These can be viewed as separate from an ACO or may reside as a bundle within an ACO population. To date, CMS has elected to carve out these episodes or bundles from the ACO and incent them as separate risk-based payment events. It may be easier to implement episode-based care as a carve-out from the ACO. This would leave more chronic care models within the ACOs where population-based care plans are better suited to population-based payments.

Question. Our health-care system is not fully equipped to care for an aging population and patients with advanced illness such as late-stage cancer, Alzheimer's disease or dementia, or congestive heart failure. This is an area where we need new models of care that reflect these challenges and create a better system for providers, patients, and their families. Many of our current Medicare rules in this space are counterproductive, such as requiring a 2-night, 3-day stay in an inpatient facility to qualify for skilled nursing care, and various disincentives to providing respite or palliative care. How are your organizations innovating to provide care for these patients, and what can Congress and CMS do to support those efforts?

Answer. The ACS would ask that Congress urge CMS to reconsider the rule that does not allow time spent as a hospital outpatient to count toward the 3-day qualifying inpatient stay for Medicare Part A coverage of care in a skilled nursing facility (SNF). Not only can services provided in the outpatient setting be similar to services provided in the inpatient setting, often the beds used for both sites of service are the same and indistinguishable to the patient and sometimes even to the clinicians. As such, a Medicare patient may not know whether he/she is admitted as an inpatient or on observation as an outpatient. In these situations, a patient could be surprised by a large medical bill when transferred to a SNF after a 3-day stay in the hospital that the patient thought was an inpatient stay.

Question. Despite continued investment, electronic health records (EHRs) remain difficult to share, challenging for patients to access, and a source of frustration to providers and policymakers alike. The business models of the EHR venders often leads to perverse incentives against sharing patient information.

What steps can Congress take to make EHRs work better for providers? Are the proposed data blocking rules enough to start encouraging better data sharing by the vendors?

Answer. Congress has been extraordinarily supportive in the implementation of digital health services through EHRs and the subsequent efforts in 21st Century Cures regarding unleashing data. This move towards standards for data models and data exchange are a necessary first step in easing interoperability and increasing patient and provider access to the complete patient record.

We believe it is time to move a layer above EHRs and begin the conversation about the *semantically interoperable, digital information system as a service in an open-standard, patient cloud.* Patients do not live in one health system or one EHR, they live in five, six, or more EHRs. Patient data also lives in third-party applications (Apps), in wearable devices, and in claims. The next generation of digital health services has to create the unified patient record in a patient cloud. The patient cloud should be an industry open standard based architecture that any digital system could use. A simple example of open industry standards are the railheads for railroads. Similarly, the electric grid is on one standard. The free market can then exploit these standards and avoid overbearing, inefficient, and costly duplicative services. Similarly, the United States needs an open standard for the architecture of a patient cloud so that any digital information company can apply the standard and create a semantically interoperable cloud. Upon these clouds, digital services like Apps can accelerate the role of the Internet of Things (IoT) in health care for all patients and clinicians.

The EHR data models are constructs from decades past and are no longer going to serve as the digital architecture of tomorrow. Building a Linux-like architecture as an open standard cloud architecture which anyone can standup and use is critical to ensuring a modern interoperable system. This open standard cloud architecture

would hold a patient unified record in a cloud upon which all EHRs could provide data, all smartphones could interact, all Application programming interface (API) developers could drop in their services for patients and clinicians. The ACS is working with cloud architects who support an open standards environment so that we do not repeat the mistakes we made with EHRs by providing perverse incentives. These efforts do not void the EHRs. The EHRs remain a point of data entry at a care site just as a smartphone or a desktop computer could also serve to enter data.

In this emerging digital information system, all patient privacy and security rights need to remain. The care patients would receive for having an open source cloud architecture would take digital health services to a new level. Congress needs to reduce the complexity surrounding digital health services and expand the opportunity by empowering Federal agencies to work collaboratively within the government and with the private sector. For now, having separate activities which lack strategic alignment between CMS, the Office of the National Coordinator of Health Information Technology (ONC), the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, and the Food and Drug Administration create enough confusion. Adding in the commercial activity and the desires of the EHR vendors to continue their dominance and the end result *will hinder innovation in one of the most important futures for health care.*

The ONC proposed rule as part of 21st Century Cures Act begins to address some of the EHR and data exchange challenges through requiring Fast Healthcare Interoperability Resources (FHIR) based APIs and U.S. Core Data for Interoperability (USCDI) data standards. We encouraged the ONC to work with vendors and specialty societies to define the data elements that are part of data exchange, and ensure that the included data are relevant and meaningful. This will help to avoid sending large amounts of irrelevant data into a new architecture. With clearly defined and reasonable standards, data exchange between EHRs to other vendors and third party applications will be manageable. We are concerned, however, that without incentives or an adjustment in reimbursement methodology, that the vendor development costs will be passed on to providers and health systems. Further, encouraging open source platforms that minimize the number of one-off connections needed for providers and health systems to share data with other entities and third party applications would ease the burden of data exchange and encourage innovation from health information technology (HIT) vendors.

While many benefits come from increased interoperability, the challenge of patient matching is heightened as data sources increase. Today, there is no consistent and accurate way of linking a patient to their health information as they seek care across the continuum. If physicians cannot ensure that we have the right patient at the point of care, we cannot properly utilize the enormous promise of the portability and interoperability of health records. We continue to encourage a *universal patient identifier* to minimize this burden, and to work with the industry to develop algorithms in the interim that use demographic data points to determine patient identity.

ACS is supportive of legislative efforts that would remove a 20-year mandate that prevented the U.S. Department of Health and Human Services (HHS) from spending Federal dollars to adopt a unique patient identifier. Removing the ban on unique patient identifier would help to ensure that surgeons have a more accurate and consistent way of linking patients to their health information across the continuum of care by providing HHS with the authority to evaluate a full range of patient matching solutions. It would also enable HHS to work with the private sector to identify a solution that is cost-effective, scalable, secure and one that protects patient privacy.

Question. How can we encourage States to be better innovators on health-care spending? The current Medicaid waivers incentivize States to keep costs down, but are there ways to encourage both lower costs and better health-care outcomes?

Answer. In order to identify how we can encourage States to be better innovators on health-care spending, Congress must understand the current landscape in the health insurance coverage space. States lack the resources to think in large scalable terms and across the landscape of uninsured, minimally insured, commercially insured, and those covered by Employee Retirement Income and Security Act of 1974 (ERISA) plans. The States react mostly to their budgets and the payment obligations, and struggle to consume a problem as complex as designing and transforming health care, one of the largest business sectors in the Nation. While we think of health care as a cottage industry which States should be empowered and able to manage, the long history of failed attempts should attest to the low level of expecta-

tions from States. The magnitude and complexity of the challenge leave most States in a quandary.

This leaves two possibilities. First, States could await a Federal solution. Secondly, Congress could consider the States as testbeds for Federal solutions and provide States with Federal guidance containing well controlled swim lanes within which they can locally innovate. If States then wish to add-on to federally guided aspects of the business and payment models in health care, these additions would come at their individual State expense.

Relying on States to take action on health care involves the commercially insured, which are mostly small businesses within a State. The larger corporations have been spared State regulations by providing health coverage under ERISA, which is regulated at the Federal level. Because of this, any actions taken by the States to test new ideas in health care are built on the backs of the small businesses that are unable to sustain themselves in the face of major health care redesign. This allows larger employers in the State to escape State-based regulations under ERISA plans even though larger corporations are more able to tolerate innovation efforts than small businesses. In order to increase voluntary uptake in testing new ideas in health care, Federal agencies overseeing ERISA plans could enact or incent innovation in health-care payments using rules and regulations.

QUESTIONS SUBMITTED BY HON. MAGGIE HASSAN

Question. We spoke during the hearing about the incentive payment for providers to improve tracking and reporting of opioid prescribing, treatment agreements, follow-up evaluations, and screening of patients who may be at risk of opioid misuse under the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA).

This data has the potential to improve treatment for substance use disorder, which is why its collection and reporting is now incentivized through increased reimbursement.

At the hearing, I asked for feedback on the impact this data collection and reporting has had on treatment of patients, particularly as it relates to any reduction in opioid misuse.

Based on your response, it seems that there may be additional steps the Centers for Medicare and Medicaid Services (CMS) could take so that this aggregated, deidentified data can be used to benefit patients and improve care.

Do you have specific suggestions on how CMS can improve the collection, use, and dissemination of opioid prescribing and treatment data sets in ways that would directly benefit patients at their site of care, specifically as it relates to identifying best practices to reduce opioid misuse?

Answer. The American College of Surgeons (ACS) thanks Senator Hassan for the opportunity to provide feedback, specifically as it relates to the opioid crisis and the data collection behind prescribing and treatment. Your question was reviewed by the ACS Opioid Taskforce [1] which is dedicated to helping prevent opioid abuse and addiction in surgical patients. Please find the College's official statement on the opioid epidemic and guiding principles here: *https://www.facs.org/about-acs/statements/100-opioid-abuse.*

Prescribing guidelines should be evidence based and written using actual data. There is a concern that a 200 morphine milligram equivalents (MME) cutoff or 7-day limit will hurt patients, increase readmissions, emergency department visits, and increase costs. Detailed articles outlining the harm of hard limits can be found here: *https://www.ncbi.nlm.nih.gov/pubmed/28697049* and here: *https://www.ncbi.nlm.nih.gov/pubmed/30004924.*

ACS would encourage the Center for Medicare and Medicaid Services (CMS) to develop evidence-based guidelines to reduce over prescribing and misuse. ACS suggests referencing guidelines like the ones released by the Mayo Clinic: *https://advancingthescience.mayo.edu/2018/04/16/new-mayo-guidelines-cut-some-opioid-prescriptions-by-half/* (Study attached).

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[1] *https://www.facs.org/education/patient-education/safe-pain-control/taskforce.*

More generally, data collection should be mobile and easily accessible at the point of care. Data collection should be focused at the population level. Narcan for example, is distributed by police, fire, emergency medical technicians (EMTs), physicians and the patients themselves. This community data should be shared with the databases of physician offices, hospitals and clinics. In order to fully understand the scope of the epidemic data should be as granular as possible.

Furthermore, ACS supports the use of fully-functioning prescription drug monitoring programs (PDMPs) as a health-care and research tool to assist physicians and other prescribers. Currently, there is wide variability between the functionality and accuracy of PDMPs from State to State. ACS strongly supports the utilization of governmental grant funding to enhance these programs and make them accessible to appropriate members of the health-care team. ACS also believes PDMPs should integrate into a clinician's natural workflow.

Patient education is also a key component to reducing opioid misuse. The ACS has developed and discriminates a wide variety of tools for physicians to use in order to education and inform their patients: *https://www.facs.org/education/opioids/patient-ed.* Public awareness campaigns such as "Change the Script"[2] led by the State of Connecticut connects "town leaders, health-care professionals, treatment professionals and everyday people with the resources they need to face prescription opioid misuse."

The ACS is committed to addressing the societal imperative to avoid the overprescribing of opioids through both patient and provider education, as well as through continued research into non-opioid pain treatments and other alternative remedies. We stand ready as a resource to Senator Hassan and the members of the Health, Education, Labor and Pensions (HELP) Committee as discussions continue on this topic.

Updated July 2018

Mayo Clinic Surgical Outcomes Program Recommendations for Adult Discharge Opioid Prescriptions

(# of Tabs of 5 mg Oxycodone or 50 mg Tramadol)

		Low Dose[a]	Standard Dose[b]	High Dose[c]
General Surgery	Endoscopy (± PEG)	NSAIDS/Acetaminophen Only	NSAIDS/Acetaminophen Only	NSAIDS/Acetaminophen Only
	Muscle Biopsy or Excisional Biopsy			**3 Tabs Oxycodone** OR* **5 Tabs Tramadol**
	MIS Cholecystectomy or Appendectomy		**8 Tabs Oxycodone** OR* **12 Tabs Tramadol**	**20 Tabs Oxycodone** OR* **30 Tabs Tramadol**
	MIS Inguinal Hernia Repair (TAPP or TEPP)			
	Open Inguinal Hernia Repair			
	MIS Bariatric, Benign Foregut, or Adrenal Surgery			
Surgical Oncology	Wide Local Excision or Lumpectomy ± SLN	NSAIDS/Acetaminophen Only	**5 Tabs Oxycodone** OR* **10 Tabs Tramadol**	**10 Tabs Oxycodone** OR* **15 Tabs Tramadol**
	Simple Mastectomy Only ± SLN		**10 Tabs Oxycodone** OR* **15 Tabs Tramadol**	**15 Tabs Oxycodone** OR* **25 Tabs Tramadol**
	Mastectomy with Subcutaneous Reconstruction ± SLN/ALND		**15 Tabs Oxycodone** AND **20 Tabs Tramadol**	**30 Tabs Oxycodone** AND **30 Tabs Tramadol**
	Mastectomy with Submuscular Reconstruction ± SLN/ALND (Recommend Diazepam 2mg tabs every 6 hours, dispense #40-50)		**30 Tabs Oxycodone** AND **30 Tabs Tramadol**	**50 Tabs Oxycodone** AND **60 Tabs Tramadol**
	MIS Abdominal Solid Organ Resection (e.g. Kidney, Spleen, or Liver Wedge)		**15 Tabs Oxycodone** OR* **25 Tabs Tramadol**	**25 Tabs Oxycodone** OR* **40 Tabs Tramadol**
	Open Major Abdominal Resection (e.g. Whipple, Esophagectomy, or Liver Resection)		**30 Tabs Oxycodone** OR* **60 Tabs Tramadol**	**50 Tabs Oxycodone** OR* **80 Tabs Tramadol**
CRS	MIS or Open Bowel Resection (Colon or Small Bowel) (Rectal surgery, resection w/ ostomy, larger incisions, non-cancer surgery, and major MIS cases may require higher dose)	NSAIDS/Acetaminophen Only	**15 Tabs Oxycodone** OR* **25 Tabs Tramadol**	**30 Tabs Oxycodone** OR* **45 Tabs Tramadol**
Vascular, Thoracic & Endocrine	Bronchoscopy or Upper Endoscopy (±Dilation)	NSAIDS/Acetaminophen Only	NSAIDS/Acetaminophen Only	NSAIDS/Acetaminophen Only
	Percutaneous Endovascular or Vascular Access Procedures (Cut-downs, Complex Endovascular, and AV Superficialization may require additional opioids)			**5 Tabs Oxycodone** OR* **10 Tabs Tramadol**
	Carotid Endarterectomy			**8 Tabs Oxycodone** OR* **12 Tabs Tramadol**
	Thyroid/Parathyroid Surgery, Mediastinoscopy, or POEM		**5 Tabs Oxycodone** OR* **10 Tabs Tramadol**	**10 Tabs Oxycodone** OR* **15 Tabs Tramadol**
	VATS Procedure (Pulmonary or Mediastinal)		**20 Tabs Oxycodone** OR* **30 Tabs Tramadol**	**40 Tabs Oxycodone** OR* **60 Tabs Tramadol**
	Thoracotomy (Pulmonary, Pleural, or Chest Wall)	**5 Tabs Oxycodone** OR* **8 Tabs Tramadol**	**50 Tabs Oxycodone** OR* **80 Tabs Tramadol**	**60 Tabs Oxycodone** OR* **100 Tabs Tramadol**

Factors Shown to Influence Opioid Usage After Discharge

←	→
Opioid Naive	Pre-operative Opioid Users
Older Age, Lower BMI, Cancer Diagnosis	Younger Age, Higher BMI, Non-cancer
Lower Pain Score at Discharge	Higher Pain Score at Discharge
Low In-hospital Opioid Use	High In-hospital Opioid Use

Clinical judgment and division level guidelines should supersede these recommendations as indicated.

[2] *https://portal.ct.gov/DMHAS/Prevention-Unit/Prevention-Files/Change-the-Script.*

Updated July 2018

***Prescribing a combination of Tramadol and Oxycodone is acceptable depending on the patients expected needs**. However, if both medications are prescribed, the number of tabs of each should be reduced. For example, if "20 Tabs Oxycodone OR 30 Tabs Tramadol" is recommended then prescribing 10 Tabs of Oxycodone AND 15 Tabs of Tramadol would be appropriate. However, prescribing a total of 50 tabs would be more than the patient would be expected to need. In addition, patients receiving opioids should still be encouraged to use NSAIDS/Acetaminophen, if not contraindicated, and these should be taken around-the-clock with opioids being used only as needed for breakthrough pain.

[a] **Consideration for Low/No Opioid Dosing**: When selecting patients for low/no opioid dosing it is important to note that prospective survey data on opioid utilization suggests that a significant proportion of patients do not need any opioids after discharge. However, consideration should be made for anticipated intensity of pain associated with the patient's condition, patient access to clinical follow-up, and the extent to which non-opioid analgesics may be utilized for adjunctive pain management (e.g., patients with contraindications to NSAIDS/Acetaminophen may require a standard level of opioids). Also consider using regional analgesia/anesthesia techniques in patients going home without opioids. It is also important to note that while providing refills requires extra cost and time to providers, internal data overwhelming supports that patients found it easy to get a refill after discharge when needed. Prescribing higher opioids to avoid the inconvenience of a refill should be avoided.

[b] **Consideration for Standard Opioid Dosing**: If opioids are deemed appropriate to manage postoperative pain, the prescription should be for the lowest possible strength of a short-acting opioid for the shortest duration of time based on anticipated pain, with a plan to taper as healing progresses. The recommended amounts in this group exceed self-reported use of 75% of patients; however, many patients use only 0-5 pills. Prescribing less opioids has not been shown to increase refill rates. Recommendations are for patients with no preoperative opioid use.

[c] **Consideration for High Opioid Dosing**: Pre-operative opioid users should in general be included in these group. Patients who are taking high doses of opioids, long-acting opioids, or have a pain management contracts preoperatively fall outside of these recommendations and a postoperative pain management plan should be developed before surgery in coordination with their primary prescriber. When prescribing high doses of opioids it is important to discuss the risk of opioids, including respiratory depression and addiction, with the patient.

Counseling:

Patients should be instructed before the procedure about their anticipated healing time, and that pain is a normal and expected part of the recovery process.

Patients should be instructed on the expected duration of needing opioids, and that most patients should be off opioids 5-7 days after discharge.

All patients should be instructed on the use of non-opioid pain medication if they are not contraindicated, regardless of dosing group selected.

Patients should be instructed on the risk of opioids, including the risk of addition.

Very few patients dispose of un-used opioids appropriately. Providers should instruct patients on the safe disposal of opioids.

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Clinical judgment and division level guidelines should supersede these recommendations as indicated.

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

Four years ago, this committee led the effort to revolutionize the way doctors are paid under Medicare. Into the dustbin of history went the out-of-date system known as the sustainable growth rate—a system that had inflicted more than a decade of uncertainty on doctors and seniors.

The new system that replaced it engraved a basic principle in stone: Medicare is going to reward the quality of care rather than the quantity of care. That's the direction that health care is headed in across the country, and Medicare ought to lead the way.

That new system established by the bipartisan MACRA law has now been in place for 2 years, and this committee has kept a close eye on its implementation. So today, the committee will hear from the doctors who operate under this system about what's working and what's not. There are a few key issues to focus on this morning.

First, all doctors should have a meaningful opportunity to succeed under the new payment system—including those in small practices and in rural and underserved areas. Oftentimes those rural physicians are the backbone of their communities, and they're relied on for a broad range of care. It's absolutely essential, as there's a greater focus on rewarding value in health care, that doctors in small and rural practices aren't left behind. Otherwise that'll degrade the care rural patients get, and it'll cause an even bigger health-care gap between big cities and small towns.

Second, when it comes to assessing quality, the goal of implementing this new system is not to have doctors checking boxes all day long. Our system needs to measure and reward the care that is most impactful for patients' health. When you're all about rewarding value, that's what matters.

Third, the system needs to continue wringing more value out of taxpayer dollars in Medicare while coordinating the care seniors need. You can do that, for example, by encouraging more doctors to provide care through Accountable Care Organizations, medical homes, and bundled payments.

One final point on the topic of physician payments as I wrap up. Last year the Congress passed a historic Medicare bill, the CHRONIC Care Act. It marked a major shift for Medicare away from being an acute care program treating broken

ankles and bouts of the flu. It recognized that modern medicine for seniors in America is about treating cancer, diabetes, Alzheimer's, and other chronic illnesses. After that progress, it's time to think about what's next.

In my view, the next step ought to be helping to guide the countless seniors who get lost in the blizzard of modern health care. Forms and prescriptions and instructions and pill bottles—it can be too much and too complicated for any one person to manage on their own.

As a former basketball player, I put the solution in basketball terms. Every senior with chronic illness ought to have what I call a chronic care point guard managing their care and making sure their doctors work together. To extend the metaphor, it's about having somebody out there running the floor. The truth is, regardless of whether an older person is enrolled in traditional Medicare or a Medicare Advantage plan, that kind of assistance could help improve care and avoid a lot of mistakes.

As for today, I want to hear from those on the ground about how the new physician payment system is working and what can be done to improve it. I want to thank all of our witnesses for joining us today, and I look forward to questions.

COMMUNICATIONS

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

The Alliance of Specialty Medicine ("Alliance") is a coalition of fifteen 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 healthcare and Medicare policy. This hearing is an important step toward continuing the promise of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and associated programs established under the Centers for Medicare and Medicaid Services' (CMS) Quality Payment Program (QPP)—the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (A–APMs)—as it was intended by the Congress.

The Alliance of Specialty Medicine believes:

- Congress should continue to make adjustments to the programs created under MACRA;
- Congress should maintain a viable fee-for-service option for providers under the Medicare program;
- Congress must safeguard beneficiaries' access to care by eliminating the 0% payment update applied to the Medicare conversion factor from 2020–2025 and replacing it with an update factor that better recognizes the Medicare Physician Fee Schedule conversion factor has failed to keep with inflation and in some instances has been reduced.
- Congress should acknowledge the slow pace of implementation of APMs by altering the timelines for bonuses embedded in statute. This includes:
  - Extending the availability of the Advanced APM 5% Incentive Payment in acknowledgement of the snail's pace of APM implementation by Medicare; and
  - Re-evaluating the qualifying participation thresholds for the A–APM incentive payment in light of the lack of implementation by CMS of qualifying APMs.

Background on Physician Engagement in MACRA

We first would like to take the opportunity to again commend Congress for enacting MACRA. This important step removed the constant threat brought to Medicare payments by the Sustainable Growth Rate (SGR). With the SGR, a destabilizing force for Medicare beneficiaries and the system overall, out of the way, Congress has provided the opportunity for all stakeholders to engage in a more meaningful discussion about how best to update Medicare payments and recognize the value of services that are provided by physicians, including specialists. We would also like to thank Congress for "technical corrections" included as part of the Balanced Budget Act of 2018, which significantly improved the ability of physicians—namely specialists—in their ability to participate in MACRA programs, and especially MIPS.

Through MACRA, Congress sought to provide flexible options for clinicians to meaningfully engage in quality improvement and value-based payment under Medicare. Members of this committee heard our concerns about legacy quality improvement programs in Medicare—the Physician Quality Reporting System (PQRS), Physician Value-Based Payment Modifier (VM) and the Medicare and Medicaid Electronic Health Record Incentive Program, or "Meaningful Use"—and in response sought to remove disparate reporting requirements, overlapping measures, and most of the "all-or-nothing" aspects of these programs and to create a streamlined system

that allows physicians to focus on the measures and activities that most closely align with their practices. As a key example of that, Congress included clinical practice improvement activities under MIPS, giving physicians MIPS credit under Medicare's payment methodology for activities designed to improve care—further encouraging physicians' ongoing engagement in quality improvement activities. More importantly, Congressional leaders understood that a viable fee-for-service option was essential to the Medicare program for those physicians, including many specialty and subspecialty providers that may never find a place in alternative payment and delivery models. While MIPS serves as an "on-ramp" for many clinicians, it serves as the ongoing value-based payment system for clinicians who must remain in a fee-for-service reimbursement construct. Under MIPS, specialists and subspecialists have 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.

The Alliance recognizes that MIPS has challenges, although the first year of the program showed significant participation by physicians. According to CMS' 2017 Quality Payment Program Experience Report, 95 percent of eligible clinicians participated in MIPS (54 percent as groups, 12 percent as individuals, and 34 percent through MIPS APMs), exceeding the agency's goal of having 90 percent of MIPS eligible clinicians participate during the first performance year. This success can be attributed to CMS' efforts to ease clinicians into the program through a transition, which began with a "Pick Your Pace" engagement strategy and determined efforts by medical professional societies to educate physicians on successful participation. For those who participated, 93 percent earned a positive payment adjustment and 2 percent got a neutral adjustment. Of note, the majority of clinicians across all payment categories chose to report data for 90 days or longer.

Despite calls by the Alliance and other medical and healthcare professional organizations, a detailed breakdown of QPP performance by physician specialty is not available nor reporting option utilization rates by physician specialty. We contend that such data should be routinely included as part of CMS' regulatory impact analyses included in annual rulemaking for the QPP. In order for medical healthcare profession associations to better educate and motivate members, it is also important for CMS to begin sharing payment adjustment data by physician specialty.

With respect to A–APMs, engagement is more challenging, particularly for specialists. First, CMS has implemented so few APMs since the passage of MACRA that meaningful opportunities to participate in APMs for most specialists does not exist. MACRA contemplated an expansion of available models with the creation of the Physician Focused Payment Model Technical Advisory Committee (PTAC). While CMS recently announced the Primary Care First model, a single model largely focused on primary care that incorporates a few elements from several different models recommended for limited-scale testing by PTAC, CMS has otherwise failed to implement models recommended by the PTAC that have addressed a broad range of physician specialties.

Existing A–APMs, such as qualifying Medicare Accountable Care Organizations (ACOs), do not fairly measure or account for the quality and costs of specialty medical care. For example, the measure sets used by current ACO models focus on measures reported by primary care providers rather than specialty care providers, making it difficult for specialists to meaningfully engage. Without measures of specialty care, ACOs seem to struggle with specialist engagement. Perhaps more concerning, and similar to health insurers, Medicare ACOs have seemingly adopted "narrow networks" as a strategy to control costs, severely limiting the participation of specialists. Other models that have been identified as Advanced APMs, such as medical home models like Comprehensive Primary Care Plus (CPC+), are also difficult for specialty care physicians to engage in, as these models are designed for primary care physicians. CMS recently announced its Primary Cares Initiative, which again, will be largely limited to primary care providers.

While a few models focus on specialty medical conditions and engage specialty physicians, these only cover a paucity of physician specialty domains. The MACRA vision of moving clinicians from fee-for-service into alternative payment models can only materialize if those models are actually implemented by CMS for potential participation. This currently leaves MIPS as the only track of the QPP for most specialists to meaningfully engage in MACRA's reforms. More importantly, some specialists may never find an appropriate A–APM given their specialty or practice size. To that end, MIPS must be enhanced for long-term viability and the timelines contemplated under the original passage of MACRA must be re-evaluated to account

for the fact that so few APMs are available and in recognition of the fact that many physicians, and specialists in particular, will continue to have payment updates based on MIPS because of this and because current APMs are not designed to account for the type of care provided by certain specialists.

MACRA and Specialists: Considerations for the Future

The Alliance appreciates the Congress' and CMS' efforts to improve the QPP and reduce the burden of participation, as well as minimize the number of clinicians subject to negative payment adjustments. Nevertheless, specialty physicians continue to face unique challenges as they attempt to engage. For example, CMS' "Meaningful Measures" initiative, which is aimed at reducing the number of measures in its quality programs, has limited the ability of specialists to meaningfully participate in MIPS as relevant measures have been eliminated. Specialty societies have made considerable investments in specialty-specific measure development, only to find CMS implementing an overly aggressive policy to eliminate what it deems are "topped out" measures. We believe that while it might be appropriate to place less of a priority on these measures from a MIPS scoring stand point, the current policy eliminates these measures when there is still measurement value, and the aggressive timeframe leaves societies with inadequate time to develop new quality measures to ensure that every specialty has a MIPS quality score based on measures meaningful to that specialty. Contrary to CMS' efforts to reduce administrative burden, this policy actually increases the burden of MIPS on those specialties that no longer have relevant measures in the program.

The Alliance and its member organizations continue to work with the agency to improve MIPS and the availability of A–APMs. To that end, the Alliance makes the following recommendations to Congress, many of which have been previously shared with CMS:

MIPS

- Eliminate the 0% payment update applied to the Medicare conversion factor from 2020–2025 and replace with positive annual updates that recognize the Medicare Physician Fee Schedule conversion factor has in the past failed to keep up with inflation and in some instances has even been reduced, provides reimbursements that keep up with the escalating costs of providing care, and supports practice efforts to invest in models of care and reimbursement based on value;
- Provide participation data in MIPS, by specialty, as part of the annual notice and comment rulemaking for the QPP;
- Remove the "all-or-nothing" aspect of the Promoting Interoperability (Pl) category by allowing eligible clinicians to select from a menu of measures that are most appropriate for their practice and patient population and gives full credit for this category for those practices that participate in a qualified clinical data registry (QCDR); and
- Simplify MIPS scoring so eligible clinicians and practice staff can have a more accurate understanding of how success can be achieved given various levels of participation.

A–APMs

- Provide participation data in A–APMs, by specialty, as part of the annual notice and comment rulemaking for the QPP;
- Extend the availability of the A–APM incentive payment (*i.e.,* the 5% APM incentive payment) beyond the 2024 payment year/2022 performance year;
- Re-evaluate the qualifying participation thresholds for the A–APM incentive payment in light of the lack of implementation by CMS of qualifying APMs;
- Provide CMS with directives on implementation of physician-focused payment models (PFPMs) and, in particular, specialty-developed PFPMs; and
- For Medicare's ACO program:
    - Establish pathways for specialists to meaningfully engage in the ACO program;
    - Provide ACOs with technical assistance that would allow them to appropriately analyze clinical and administrative data, improving their understanding of the role specialists could play in addressing complex health conditions, such as preventing acute exacerbations of comorbid conditions associated with chronic disease;
    - Establish requirements that prohibit ACOs from restricting specialist participation;
    - Closely examine the referral patterns of ACOs and establish benchmarks that will foster an appropriate level of access to and care coordination

with specialists, in addition to collecting feedback from beneficiaries on access to specialty care;
- Develop an ACO quality measure that would capture the percentage of physicians reporting to specialty-focused clinical data registries; and
- Adopt specialty designations for non-physician practitioners to ensure specialty practices are not inadvertently forced into exclusivity.

MedPAC Recommendation to Eliminate MIPS

In 2018, the Medicare Payment Advisory Commission (MedPAC) recommended the elimination of MIPS based on its conclusion that the basic design of MIPS is fundamentally flawed. The Commission contends that MIPS will not succeed in helping beneficiaries choose clinicians, in helping clinicians change practice patterns to improve value, or in helping the Medicare program reward clinicians based on the value of the care they provide. To address these concerns, Med PAC further recommended implementing a voluntary value program (VVP) that would measure large groups of physicians on population, outcome, and patient experience measures. Details about the VVP are anticipated in future Commission work; however, the concept at its broadest level ensures that most specialists will be unable to meaningfully engage as the measures MedPAC has suggested are those CMS uses in its other quality programs and focus on primary care activities and population health.

The Alliance strongly opposes MedPAC's recommendations for the reasons cited below:

- There is a significant lack of A–APMs in which specialists can meaningfully engage;
- The measures contemplated for use under a VVP will be limited in their ability to determine quality and cost of specialty medical care;
- Specialty providers have very little control over the activities that affect performance on the measures contemplated for use under a VVP; and
- MACRA very clearly intended to promote the development of clinically relevant, specialty-based quality measures. MIPS, and fee-for-service, remain a viable reimbursement structure for many specialists and subspecialists and must be maintained.

Instead of the MedPAC recommendation to scrap the progress that has been made thus far on the implementation of MACRA, in addition to the provisions suggested above, we believe the following steps, many of which can be taken by CMS, will help make the QPP a better system on which to base physician payment updates than what is suggested by MedPAC under the VVP:

- Streamline the program to avoid the siloed scoring of the current four performance categories;
- Condense the amount of time between performance and payment years in order to provide more meaningful feedback and incentives;
- Reduce the reporting periods to an amount of time that provides reliable data but reduces the administrative reporting burden placed on practices; and
- Promote the inclusion of measures that recognize the value of specialty care rather than broad primary care-focused measures that only apply to a subset of services provided in the context of the Medicare Physician Fee Schedule.

Conclusion

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 treatment options are most appropriate based on their preferences and values, and coordinate and manage patients' specialty and related care until treatment is complete. No other clinician, provider or health care professional can replace the value offered by specialty physicians. At the same time, specialty physicians have had limited opportunity to engage in value-based transformation through available A–APMs that are targeted to their specialties, and the likelihood of widespread future models tailored to their expertise remain low. To that end, MIPS must continue to be improved for long-term viability since it will be the only option for many of these specialists to engage in value-based payment given they will have no other option than to remain in fee-for-service.

Finally, while we are confident that successful implementation of the idea cited above will make strides in developing a more meaningful QPP for patients, physicians, and for Medicare as a payer, we also believe that it will be important to begin having a larger conversation about the siloed payment systems in Medicare that fail to recognize the impact that specialists have on inpatient and outpatient hospital

spending. Physicians have been asked to bear the brunt of Medicare spending increases with payments that are sometimes cut, certainly fail to keep pace with inflation, and fail to even measure up to the payment increases included in MACRA. For instance, in 2016, the first year that the MACRA 0.5% base payment update was implemented, the Medicare Physician Fee Schedule conversion factor actually *decreased* by −0.34% going from $35.9335 in 2015 down to $35.8043 in 2016. In no subsequent year did the actual conversion factor increase match the 0.5% contemplated in statute, and 5 years later we stand at a Medicare Physician Fee Schedule conversion factor of $36.0391, only nominally above the 2015 conversion factor. During this time, hospitals continue to get significant across-the-board Medicare payment increases based on an inflationary update in addition to their value-based purchasing program updates. CMS has proposed a general fiscal year (FY) 2020 payment increase for inpatient hospitals of 2.7%. The inequity between these payment systems will continue to exacerbate issues in our health care delivery system, undermine the value of the services physicians provide to their patients while throwing money at brick-and-mortar investments, and fail to recognize that patients are best supported when the payment systems reflect the actual care delivery system.

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 committee to ensure MACRA continues to be successful, and we would be happy to discuss any other questions you may have going forward.

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Thank you for holding an important oversight hearing on implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The American Academy of Ophthalmology appreciates the opportunity to submit a statement for the record. As the world's largest association of eye physicians and surgeons, the Academy seeks to protect sight and empower lives by setting the standards for ophthalmic education and advocating for our patients and the public.

The Academy, along with most of the healthcare community, supported MACRA and the repeal of the Sustainable Growth Rate formula. Moving to a new payment system that works to reward quality patient care, improve outcomes, and ensure cost effectiveness in the Medicare program is important to the Academy. While a small specialty, the fact that the majority of ophthalmology's patients are Medicare beneficiaries makes us vital to the new Medicare physician payment program.

The best way to achieve MACRA's aims is with continuous quality improvement; this is the driving force for our implementation of the Academy's IRIS® Registry (Intelligent Research in Sight)—the nation's first comprehensive eye disease clinical registry.

CMS's slow ramp up (Pick your Pace) allowed practitioners and their specialty organizations needed time to prepare to meet the requirements of the new Quality Payment Program (QPP). Because of this necessary ramp up, there is naturally a delay in seeing evidence of significant improvement for beneficiaries and patient outcomes.

The IRIS Registry:

Just 5 years since its launch, IRIS Registry is the world's largest single specialty clinical data registry. Today, nearly 18,000 physicians are contracted with the IRIS Registry, and nearly 15,000 of these physicians are integrated with IRIS Registry through their electronic health record (EHR). This integration allows seamless transmission of quality data points from the patient records into the registry each night, easing the reporting burden for clinicians. This works to level the playing field, facilitating participation of small and rural practices in MIPS. More than 70 percent of U.S. actively practicing ophthalmologists participate in the IRIS Registry. This high participation rate is bolstered by two factors:

- The high percentage of our ophthalmologists that must participate in MIPS; and

- Actionable information provided in a timely fashion that allows our members to implement effective quality improvement measures of direct benefit to patients independent of the QPP.

More than 20 other specialties have initiated similar EHR integrated clinical data registries that, like IRIS Registry, have been recognized as a qualified clinical data registry (QCDR) under MIPS. The Academy made the major commitment to develop a clinical data registry to advance true improvement in quality of care and patient outcomes, devoting significant resources and investing more than $13 million. Participation is free for member ophthalmologists which has helped foster a collaborative and inclusive program. The Academy is committed to making MIPS work for Medicare and ophthalmology because there is little opportunity on the horizon for non-hospital-based specialties to participate in and achieve status as Advanced Alternative Payment Models (AAPMs).

For 2019 MIPS, CMS approved 28 QCDR measures for the IRIS Registry developed by the Academy with our subspecialties. The vast majority of these measures are outcome measures. Our goal is to provide at least two outcome measures of quality that effectively represent relevant performance and outcomes for each of ophthalmology's nine subspecialties.

Areas for Improvement Under MIPS:

Low Volume Threshold—MIPS has not been without controversy. Under the significant low volume exclusion threshold established by CMS, two-thirds of practitioners are not required to participate in the QPP. This appears to be contrary to Congress' commitment to value-based care under Medicare. Ophthalmology, and a few other specialties, have the highest percentage of clinicians required to participate in MIPS. This means that our members are at a higher risk for significant penalties under MIPS/MACRA than other specialties, and we do not believe that Congress intended this risk inequity when the law was enacted. In addition, the limited participation overall in the QPP hampers the health system transformation that Congress envisioned from MACRA.

Web Interface Reporting Option—The low-volume threshold is not the only policy in CMS's QPP that introduces inequities among MIPS participants. For example, the web interface reporting option is only an option for very large practices. Under this reporting option, very large groups report on 10 primary/general care measures for a subset of 248 patients. No specialty outcome measures are included. Therefore, specialty care in these groups essentially goes unevaluated, leaving CMS and patients with no insight into the quality of care provided by the large volume of specialty practitioners in these very large groups. In stark contrast, physicians who do not practice in these very large groups are held individually accountable for outcomes pertinent to their specialty. This introduces a bias where a higher bar is set for physicians in smaller practices. In other words, this is a double-edge sword. The CMS Web Interface reporting policies result in the following: (1) a higher reporting burden on small practices than on the very large practices; (2) limit the potential quality care improvement in very large practices; and (3) reduce the public's ability to select specialists on the basis of quality metrics.

Healthcare Consolidation—Furthermore, the Web Interface reporting option for very large groups may incentivize a trend in healthcare that both HHS and Congress have been trying to stem—consolidation. Consolidation has been shown to contribute to increased healthcare costs.

Small Practices—In addition to the large practice bias introduced by the Web Interface reporting policies, a recent article in *Health Affairs* highlighted the challenges small practices face complying with QPP/MIPS. Specifically, small and rural practices had significantly lower MIPS scores. We recommend that CMS reinstate the small practice 5 percent differential/bonus on the total score. In addition, score improvements for small practices continue to be needed in the Quality Component and current differentials should be retained.

Expanding QCDR Credit—In the MACRA legislation, Congress foresaw the difficulty in creating germane and more dynamic measurements of quality performance among specialists and specifically instructed CMS to incentivize the use of QCDRs. However, CMS has indicated its intention to remove these even limited or small incentives altogether. Recently, the Brookings Institute raised concern about the outlook for MIPS but called for a standalone bonus/recognition for clinical data registries that are clearly improving care. To help achieve the goals of the law and improve quality of care, patient outcomes and costs, CMS should follow congressional

intent and increase its credit for practitioners that participate in proven quality improvement initiatives such as certain clinical data registries.

Ways that Medicare is benefiting from incentivizing QCDRs/Clinical Data Registries:

Quality Improvement—Registries have been demonstrated to improve quality of care and outcomes. A study published in *Ophthalmology* documented improvement on quality measure performance as a result of the feedback provided by the IRIS Registry.[1] This includes improvements in lowering high risk medications for the elderly, and improvement in lowering the complications after cataract surgery. While one of the most successful procedures, cataract is also one of the most frequently performed procedures under Medicare. Even a small reduction in cataract complications has a substantial impact for Medicare.

Value Improvements—At a time when there was much public concern about the risks of compounded pharmaceuticals, IRIS Registry data has been used to show that there is no statistical difference in the rates of endophthalmitis in age-related macular degeneration (AMD) patients by anti-vascular endothelial growth factor (VEGF) agent, helping to preserve practitioner and beneficiary confidence in repackaged, off-label treatments for AMD and diabetic retinopathy. Studies using registry data could bring significant cost savings to Medicare. For example, preserving the option to use Bevacizumab for AMD treatment is estimated to save the Medicare program and patients in the billions.[2]

Real World Evidence—The IRIS Registry has also helped to demonstrate the safety of commonly performed procedures. One study showed that in real-world usage, anti-VEGF intravitreal injections are associated with a small decrease in intraocular pressure, and not an increase in intraocular pressure.[3] Another study demonstrated that cataract surgery is associated with a very low rate of endophthalmitis, a vision-threatening complication, at 0.08%.[4]

Conclusion:

The Academy applauds the Committee for conducting its oversight hearing on the implementation of the Medicare Access and CHIP Reauthorization Act. As implementation of the law continues, we look forward to working with the Committee to improve both the QPP and MIPS to ensure that participating physicians have opportunities to succeed and the push for a quality-driven healthcare system continues.

When Congress enacted the MACRA, it created the QPP to streamline Medicare's existing quality improvement programs and reduce the regulatory and administrative burdens on physicians. Congress envisioned QCDRs like the Academy's IRIS Registry to be a meaningful solution to achieving the QPP's goals and directed the HHS Secretary to encourage clinical data registries in the law's implementation.

Therefore, Academy recommend that Congress reiterate its support for specialty-led clinical data registries and strongly encourage CMS to increase credit under the QPP/MIPS to eligible practitioners who voluntarily participate in registries. For example, a highly valuable move and important step would be to create a pathway through which EHR-integrated registry participants could fully qualify for the Promoting Interoperability (PI) category of MIPS. PI is the most onerous category of the MIPS program, and a registry pathway would significantly reduce practitioner burdens and improve participation in specialty-led registries.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

Between 2013 and 2015, the American Academy of Ophthalmology (AAO) received funding from the Agency for Healthcare Research and Quality (AHRQ) under the Developing Evidence to Inform Decisions about Effectiveness (DEcIDE) Program, to

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[1] Rich WL 3rd, Chiang MF, Lum F et al. "Performance Rates Measured in the American Academy of Ophthalmology IRIS Registry (Intelligent Research in Sight)." *Ophthalmology.* 2018; 125:782–4.

[2] Rosenfeld PJ, Windsor MA, Feuer WG et al. "Estimating Medicare and Patient Savings From the Use of Bevacizumab for the Treatment of Exudative Age-related Macular Degeneration." *Am J Ophthalmology* 2018; 191:135–139.

[3] Atchison E, Wood K et al. "The Real World Effect of Intravitreous Anti-VEGF Drugs on IOP: An Analysis Using the IRIS Registry." *Ophthalmology,* 2018; 125:676–82.

[4] Coleman AL. "How Big Data Informs Us About Cataract Surgery: The LXXII Edward Jackson Memorial Lecture." *Am J Ophthalmology* 2015; 160:1091–1103.

disseminate the Registry for Glaucoma Outcomes Research (RiGOR) study findings through the use of social media tools.

The American Academy of Ophthalmology is a 501c(6) educational membership association.

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May 7, 2019

The Honorable Chuck Grassley
U.S. Senate
135 Hart Senate Office Building
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The Honorable Ron Wyden
U.S. Senate
221 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Grassley and Ranking Member Wyden,

On behalf of the American Association of Orthopaedic Surgeons (AAOS), we would like to express our appreciation for holding a hearing on Medicare physician payment reform and the Medicare and CHIP Reauthorization Act (MACRA). This is a high priority issue for our members, and we have closely been monitoring MACRA's progress and effects on the AAOS membership. AAOS represents over 34,000 orthopaedic surgeons and residents, as well as musculoskeletal patients nationwide.

The AAOS commends Congress on its efforts to improve access to high quality, high value health care. We hope the opportunity to provide input on MACRA, as well as other proposals and policies impacting physician quality measurement and reporting practices, will shape the continued development and improvement of these programs. We have provided our comments below.

MACRA Implementation and Progress

We are pleased that the Center's for Medicare and Medicaid Services (CMS) agreed to our request for a gradual buildup of penalties starting in 2018. With the implementation of MACRA under CMS' Quality Payment Program (QPP), as well as numerous other regulatory changes, physicians are navigating a complex new reporting system. Indeed, many are still working to understand the new requirements and prepare necessary infrastructure and education.Congress should continue to make program reforms that allow physicians to adequately prepare for the increasingly complex and ever-changing regulatory environment.

Additionally, AAOS encourages removal of the requirement to report on all patients going forward. It is widely known that orthopaedic medicine lacks validated patient reported outcome-based performance measures (PRO–PM) and has few process measures. AAOS suggests that in areas where there are no validated clinical-level quality measures, and until the time these are developed, physicians be allowed to participate in the Merit-based Incentive Payment System (MIPS) voluntarily.

For payment year 2019, for an eligible clinician to become a qualifying participant they must receive 50 percent of their Medicare part B payments or see at least 35 percent of Medicare patients through an Advanced APM entity to receive the 5 percent Advanced APM bonus. These thresholds are almost impossible even for our high-volume surgeons who participate in BPCI Advanced. AAOS urges Congress to provide reasonable thresholds so that surgical clinicians can adequately participate and become a qualifying program participant.

Clinical Data Registry Participation and Incentives

AAOS has invested significantly in our family of clinical data registry programs, including quality collection measurement functionality and components. Within orthopaedics, a growing number of AAOS members participate in these registries such as the American Joint Replacement Registry (AJRR), which collects data that would be useful in quality reporting. Many other medical and specialty societies operate registries of various scopes and sizes, and the vast majority of these registries contain relevant data on quality. Other entities operating registries include integrated health care systems (*e.g.,* Kaiser, Geisinger), Accountable Care Organizations, and Independent Physician Associations.

If registries or other existing quality reporting programs report to CMS, a common set of variables should be required across all reporting entities. The list of required

common variables should be developed in collaboration with medical specialty societies. Additionally, data must be appropriately risk-adjusted for each physician's particular case mix, including co-morbid conditions, to facilitate meaningful and relevant comparisons among physicians. Lastly, physicians should have the opportunity to request audits of their quality data and have due process to address any errors.

Quality reporting systems also need to become more user-friendly and more tailored to specific specialties, particularly surgical specialties. Significant progress needs to be made in developing valid, relevant, patient-centered measures of physicians' quality of care. These measures should be expanded to include patient outcomes, patient safety measures, and experience of care.

There is also not currently a path for registries to participate as an Alternative Payment Model (APM). AAOS strongly advocates for the opportunity to allow physicians to qualify for payment updates under MACRA for participation in a qualified clinical data registry (QCDR).

Alternative Payment Models (APMs)

We strongly urge Congress to discourage the mandatory nature of the proposals coming out of CMS and instead create incentives for interested participants that would reward innovation and high-quality patient care. We believe the programs should be voluntary for any set of surgeons, facilities, and providers who seek to collaborate in innovative ways to bring higher quality, coordinated, and lower costs for musculoskeletal care and who have the infrastructure necessary to carry out an episode of care approach to payment and delivery. Specifically, we recommend that CMS require that any participating entity have verifiable interoperability, infrastructure, and agreements between all necessary entities.

Conclusion

The AAOS has committed considerable member and financial resources to developing and analyzing evidence-based process and outcome measures and encouraging the adoption of evidence-based practice guidelines for the prevention, diagnosis, and management of musculoskeletal diseases. We invite CMS to call on us as an involved partner and subject matter expert in evidence-based performance and quality measurement in musculoskeletal care.

We look forward to working with you and other stakeholders to ensure the continued success of MACRA and other related physician payment programs. Please feel free to contact Madeline Kroll, Manager of Government Relations (kroll@aaos.org), if you have any questions or if the AAOS can further serve as a resource to you.

Sincerely,

Wilford Gibson, MD
Council on Advocacy Chair, American Association of Orthopaedic Surgeons

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The American College of Physicians (ACP) appreciates the opportunity to share our views regarding Medicare physician payment reform under MACRA, the implementation of this law after two years, and the road ahead for physicians to ensure a health care delivery system that rewards the value and quality of care provided to patients. We thank Senate Finance Chairman Grassley and Ranking Member Wyden for hosting this hearing to hear the view of physicians concerning MACRA in order to ensure that it is implemented successfully and as intended by Congress. As Congress considers oversight or potential legislative changes to MACRA, we urge you to take steps to improve Medicare payment policies in ways that better align payments with the value of care provided to patients, reduce unnecessary administrative burdens that divert physicians away from patient care, ensure that performance measures used for payment or public accountability are evidence-based, clinically relevant, and appropriate, and create more opportunities for physicians to lead and participate in alternative payment models.

ACP is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 154,000 internal medicine physi-

cians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Overview of the First Two Years of MACRA

In order to provide an accurate assessment of whether the new payment systems under MACRA have provided adequate support and reimbursement for physicians to continue to provide high quality value-based care for their patients, it is essential to examine how physicians fared during the first two years of MACRA implementation. ACP has examined the results of the Quality Payment Program (QPP) Experience Report based on the 2017 participation rate in Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). There are several positive results from this survey that acknowledge in some degree that MACRA is working as it intended. The 2017 results show that the participation rate of physicians in MACRA was 95 percent and that only five percent of the physicians received a penalty. However, the bar for entry into MACRA was set very low, by design, to ensure that in the first year physicians could adequately transition into MIPS or Advanced APMs. In the 2017 Quality Payment Program, known as Pick Your Pace, physicians could avoid a penalty by submitting only three points, which could have been as easy as submitting one quality measure on one patient for the entire year. We may find a more accurate reading of how well physicians fared under MACRA by looking at the 2018 data, when it is released, where physicians were required to submit 15 points to avoid a penalty. The performance standard for physicians is even higher in 2019, as they are now required to submit 30 points to avoid a penalty.

The 2017 QPP results also show that small practices lagged behind larger practices in their overall performance rating for the QPP. The average score for small practices was more than 30 points lower than the average overall score, and rural groups also lagged 11 points behind. Small practices were almost 20 percent less likely to earn a bonus and 14 percent more likely to get a penalty than the average across all practices. One factor that may prohibit smaller practices from succeeding in the QPP is that they often do not have the capital to build the office infrastructure necessary to make investments in their practices so that they may meet the requirements of the QPP program.

Small practices were also less likely to report more than 90 days of quality data which was optional in 2017 but became mandatory in 2018. The data show that while 74 percent of all practices reported quality data for a full year only 67 percent of rural and 44.5 percent of small practices reported a full year of QPP data.

ACP is disappointed that despite repeated objections from the vast majority of stakeholders including the College, CMS continues to require a full year of quality and cost data. We ask the Senate Finance Committee to weigh in with CMS in the strongest possible terms to urge the agency to reconsider this policy and reconsider instituting a consistent, minimum 90 consecutive day minimum reporting period across all MIPS performance categories. Lowering the minimum reporting period to 90 consecutive days would drastically reduce reporting burden, allow time to implement EHRs or other innovative technologies without risk of compromising MIPS reporting or performance, allow for more timely performance feedback, and reduce the two-year lag between performance and payment. Moreover, 90 days would be a minimum; while 90 days is a sufficient length of time to capture reliable data for the majority of measures, individual measures could have their own separate minimums so that data accuracy would not be compromised.

THE MIPS PROGRAM

The majority of physicians participate in the QPP through the MIPS track, which builds on traditional fee-for-service payments by adjusting them based on a physician's performance. The MIPS program measures physicians' performance based on a scoring structure that requires physicians to report performance data to CMS in four weighted categories: Quality Measurement (45 percent-weight), Improvement Activities (15 percent), Promoting Interoperability (25 percent), and Cost (15 percent). Physicians receive a score based on how well they perform in each of these categories, which then determines their Medicare payment. This scoring structure is unnecessarily complex because each category has its own unique scoring methodology and because the value of any measure or activity is scored out of an arbitrary number of points that has no correlation to its weight relative to the final MIPS score. Moreover, the categories are siloed, preventing any cross-category credit, and

the measures on which physicians must report are overly burdensome and do not measure what matters.

The MIPS program was intended to create a more streamlined approach for physicians to report performance measures through a unified program rather than through several different performance measurement programs as required prior to the authorization of MACRA. This program has not worked as Congress intended. *We urge the Senate Finance Committee to exercise their oversight authority to urge CMS to simplify the scoring structure and reporting requirements under MIPS in order to fulfill Congress' intent of a more streamlined program that reduces burdens on physicians.*

MIPS Scoring

The College reiterates our previous concerns that the separate reporting requirements and scoring methodologies for each category are confusing for clinicians and counter to CMS' efforts to minimize burden and create a unified program. One simple solution would be to assign point values for each measure proportionate to their overall value relative to the MIPS composite score. The total points in the Pl Category would total 25 for example, and so on. This methodology has the support of a number of physician groups, and also would allow CMS to continue distinguishing high-priority measures and categories with more value while creating a more intuitive, streamlined scoring approach. We encourage CMS to take every opportunity to award cross category credit. Doing so will create synergy between the various performance categories and align incentives to drive meaningful improvement in critical priority areas, rather than spreading practices too thin across too many metrics. This will lead to better patient outcomes and less burden on clinicians and practice staff.

Quality Category

This category, and MIPS in general, needs more relevant, accurate, and effective quality measurement, particularly measures based on patient outcomes. We urge the Finance Committee to weigh in with CMS to reduce the number of measures required for full participation in this category from six to three measures. ACP's Performance Measurement Committee (PMC) conducted a study of many of the performance measures included in the MIPS program, applicable to internal medicine, and found that only 37 percent were rated as valid, 35 percent as not valid, and 28 percent as of uncertain validity. Measures should be evaluated against four critically important criteria: importance to measure, scientifically acceptable, usable and relevant, and feasible to collect. CMS should collaborate with specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of new quality measures with a focus on integrating performance measurement and reporting within existing care delivery protocols to maximize clinical improvement while decreasing clinician burden. A majority of new MIPS measures finalized for 2019 have received only conditional support from the Measure Application Partnership (MAP), and previously adopted measures remain despite being recommended for "continued development" by the MAP, a designation reserved for measures that lack evidence of strong feasibility and/or validity. MAP is a multistakeholder partnership that guides the U.S. Department of Health and Human Services (HHS) on the selection of performance measures for federal health programs.

It is imperative CMS ensure that a transparent, multi-stakeholder process is used to evaluate all measures used in its programs. The National Quality Forum (NQF), for instance, evaluates measures against four critically important criteria: importance to measure scientificallyacceptable, usable and relevant, and feasible to collect. CMS should also collaborate with 8 specialty societies, frontline clinicians, patients, and EHR vendors in the development, testing, and implementation of new quality measures with a focus on integrating performance measurement and reporting within existing care delivery protocols to maximize clinical improvement while decreasing clinician burden. Further, the criteria and processes CMS uses to make its final decisions regarding which measures to remove from the program and which to continue using should also be fully transparent. This would allow stakeholders to better plan their efforts in terms of measure development and review and provide more meaningful feedback to the Agency in the future.

Cost Category

Under current statute, MACRA will require CMS to increase the weight of the cost category to 30 percent by performance year 2022, but we urge Congress to revise the timeline to afford CMS additional flexibility just as it did with the Bipartisan Budget Act. The problem with maintaining the current timeline for an increase in the

weight of the cost category is that the measures used to evaluate the cost of care are not adequately reliable and accurate. We appreciate CMS' repeated efforts to engage stakeholders in the measure development process. However, we have serious concerns about moving forward with eight new episode-based cost measures that have low average reliability and have not been given an adequate opportunity to be fully vetted by stakeholders. ACP shares the goal of the cost category to reward physicians who are delivering high quality, efficient care, but this only works with accurate cost and quality measurement. Otherwise, a host of unintended consequences could ensue, such as clinicians being penalized for treating sicker or older patients that may require more expensive care.

Promoting Interoperability (PI) Category

ACP continues to call for the PI Category to be re-conceptualized into a performance category that promotes the use of health IT to improve patient care and support practical interoperability. While we appreciate CMS's attempt to simplify and streamline the PI category in the 2019 QPP final rule, the Agency continues to use the same "EHR-functional-use" measures that clinicians have found to be cumbersome and inappropriate and do little to help clinicians move forward in using their health IT to improve the value of patient care. *CMS should further update the PI performance category such that the current "EHR-functional-use" measures (*e.g., *e-prescribing and health information exchange [HIE] measures) are not scored on an "all-or-nothing" basis and that one minor misstep by a clinician could result in a score of zero for the entire category. CMS should then add in optional measures and activities (similar to the Improvement Activities component of MIPS) where clinicians can choose and attest to health IT activities that leverage health IT to improve patient care and better fit certain specialties and scopes of practice.*

ALTERNATIVE PAYMENT MODELS

Although we are pleased that CMS recently announced the creation of two new APMs (Primary Care First and Direct Contracting) that will be available for physicians to join in the future, we are disappointed that to date, there are only eight active distinct types of Advanced APMs. The number of available models falls well short of the robust pathway to value-based reform that Congress had envisioned for APMs and does not support the Agency's own stated goal of shifting physicians into APMs.

We encourage the Senate Finance Committee to use their oversight authority over CMS to encourage the agency to leverage the Physician-focused Payment Model Technical Advisory Committee (PTAC) which could be an invaluable tool to facilitating the implementation of innovative new physician-led APMs but to date has unfortunately been underutilized. Few of the now 11 models recommended for limited scale testing or full-scale implementation have been adopted by CMS. Many of these models have a proven track record of working in the private sector; it is to CMS' benefit to capitalize on the substantial investment and testing that has already gone into these models. Moreover, we have already seen a decline in the number of submissions to PTAC. The longer CMS goes without adopting any models, what could be a great launching pad for a variety of innovative new payment models could cease to serve any practical purpose as enthusiasm wanes and developers cease to invest the resources and time into developing models without a realistic chance of those models ever being adopted.

Physicians who qualify to deliver care in an Advanced APM also receive a five percent bonus if they meet certain metrics and use certified Electronic Health Record Technology, which then excludes them from MIPS reporting requirements, a huge incentive. Unfortunately this 5 percent bonus is set to expire in 2022 unless Congress approves legislation to extend it. We are concerned that if physicians are not assured that this five percent bonus will be available in the future, they would be less inclined to invest in the necessary infrastructure transformation in their practices to deliver care in an Advanced APM. *Because one of the goals of MACRA was to encourage physicians to transform their practices into Advanced APM's, we urge Congress to extend the 5 percent bonus beyond 2022 to continue to provide the necessary incentives for physicians to deliver care in this model.*

An additional barrier that prevents physicians from transforming their practices into Advanced Alternative Payment Models is that physicians are required to bear significant financial risk, either 3 percent of estimated expenditures or 8 percent of average estimated Medicare Parts A and B revenue in order to participate in an APM. CMS intended for this threshold of participation as the standard for "nominal" risk so that additional practices to transform into APM's but this threshold is simply too high to be considered a nominal financial risk. CMS should also consider

that physicians have to invest a significant amount of capital in order to afford the infrastructure improvements and practice transformation required to participate in an Advanced APM. This threshold is especially difficult for smaller and rural practices who desire to participate in APMs but often lack the sophisticated infrastructure, financial reserves to purchase technologies required for interoperability or quality improvement, and ability to take on risk that immediately puts them on uneven ground when it comes to participating in Advanced APMs. *We encourage the Finance Committee to support a separate, lower Advanced APM nominal amount standard to encourage additional participation in Advanced APMs especially for small and /or rural practices.*

NEW PAYMENT MODELS ANNOUNCED BY CMS

ACP is encouraged that CMS is testing new delivery and payment models to support the role of care provided by primary care physicians. Last month, the Department of Health and Human Services announced the creation of two new payment models, known as Primary Care First and Direct Contracting. These models are intended to recognize the value of primary care physicians in our health care system by offering sustainable and predictable prospective monthly payments to practices, to reduce administrative burdens for clinicians, to increase the quality of care for patients, and to allow practices and their physicians to share in savings from keeping patients healthy and out of the hospital whenever possible.

Internal medicine specialists are uniquely trained to provide adult patients with primary and comprehensive care throughout their lifetimes, and ACP is supportive of new primary care models that recognize and support their contributions to bringing greater value to their patients. The new models are important steps in this direction. Specifically, ACP is pleased that CMS has considered our recommendations to provide a variety of payment and delivery models that support internal medicine and primary care practices, from smaller and independent practices to larger integrated ones. Of note, ACP is optimistic that the new models will emphasize the important role primary care plays in value-based care delivery, that models are voluntary and have a range of risk options, and that practices should use population health management data to reap potential benefits. Additionally, ACP is supportive of the fact that the new models aim to reduce administrative burdens-potentially allowing physicians to spend more time with their patients.

We are especially interested in the Primary Care First Model that "will focus on advanced primary care practices ready to assume financial risk in exchange for reduced administrative burdens and performance based payments." As noted in the CMS fact sheet on this model:

- *Primary Care First Model*—to be eligible to participate in the PCF model, a practice must include "primary care practitioners (MD, DO, CNS, NP and PA), certified in internal medicine, general medicine, geriatric medicine, family medicine and hospice and palliative medicine." It must have 125 attributed Medicare beneficiaries at a particular location, have primary care services account for at least 70% of the practices' collective billing based on revenue, and in the case of a multi-specialty practice, 70% of the practice's eligible primary care practitioners' combined revenue must come from primary care services. It must also "have experience with value-based payment arrangements or payments based on cost, quality, and/or utilization performance such as shared savings, performance-based incentive payments, and episode-based payments, and/or alternative to fee-for-service payments such as full or partial capitation."

There are elements of the PCF model that suggest that CMS is on the right track to building models that will improve patient care and that will support the work of primary care physicians. It provides a variety of payment models that will support internal medicine and primary care practices, from smaller and independent practices to larger integrated ones; it includes a range of risk options available to practices, and it could potentially reduce administrative burdens that would allow physicians to spend more time with their patients.

However, a lot of details related to risk adjustment, attribution, and financial benchmarking are still missing that may determine how many physicians and practices will seek to participate. Also, unless other payers join Medicare in supporting the PCF model, practices may not experience the reduction in administrative burdens and predictable revenue that CMS anticipates. Presumably, CMS will be releasing such information soon, prior to the enrollment period it intends to begin this fall. As CMS moves forward with the development of new care models, we urge the continued creation of new Advanced APMs that include multiple payers so that all patients, not just Medicare beneficiaries, may benefit from the innovations and im-

provements to patient care that these models may provide. This will also allow those practices that voluntarily support these innovative care delivery system reform models to focus on a unified set of metrics and goals, allowing them to focus on truly improving patient care in key strategic areas and get back to delivering patient care, rather than juggling dozens of sets of varying reporting metrics.

Although there is great potential that these models will reinvigorate the practice of primary care physicians, we believe the success and viability of these models will depend on the extent that they are supported by payers in addition to Medicare and Medicaid, are adequately adjusted for differences in the risk and health status of patients seen by each practice, are provided predictable and adequate payments to support and sustain practices (especially smaller independent ones), are appropriately scaled for the financial risk expected of a practice, are provided meaningful and timely data to support improvement, and are truly able to reduce administrative tasks and costs, among other things. ACP will continue to evaluate the new payment and delivery models based on such considerations, and we look forward to working with CMS and to continue advocating for ways to support the value of primary care for physicians and for all patients across the health care system."

THE FUTURE OF MACRA

After MACRA was passed in 2015, the law established a period of positive Medicare payment updates of .5 percent until the end of 2019, which are then adjusted upward or downward based on reporting on performance measures. After this year, physicians will receive a zero percent Medicare baseline payment update from 2020–2025. We remain concerned that a zero percent update from 2020–2025 does not provide adequate support for physicians to continue to make the necessary adjustments to perform at a high level on standards set by MACRA to measure quality, clinical improvement, interoperability, and cost data related to their practices. As noted in the testimony concerning this hearing submitted by the American Medical Association, the recent 2019 Annual Medicare Trustees Report found that scheduled physician's payment amounts are not expected to keep pace with average rate of physician cost increases, which are forecast to average 2.2 percent per year in the long range. The Medicare Trustees Report also found that absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term. *We encourage members of the Senate Finance Committee to introduce and pass legislation that would replace the zero percent baseline payment updates under Medicare, scheduled to take effect in 2020, with positive updates.*

SUMMARY OF ACP KEY RECOMMENDATIONS

As the Senate Finance Committee conducts oversight over CMS implementation of the Quality Payment Program under MACRA and also considers legislative changes to this law, we offer the following key recommendations to ensure that MACRA is implemented successfully and as intended by Congress.

Members of the Senate Finance Committee should encourage and provide incentives to physicians who transform their practices into Advanced APMs and continue to provide stability for physicians in the MIPS program by introducing and passing legislation that would do the following:

- Extend the five percent Qualified APM participant bonus beyond the 2022 performance year.
- Replace the zero percent baseline payment updates under Medicare, scheduled to take effect in 2020, with positive updates.
- Revise the timeline to afford CMS with additional flexibility to determine the weight of the cost category within MIPS. It is scheduled to be 30 percent by performance year 2022.

Members of the Senate Finance Committee should exercise their oversight authority over CMS and urge it to implement the following recommendations:

- Expedite approval of more Advanced Alternative Payment models (APMS), particularly those that work for small and specialty practices.
- Provide a separate, lower Advanced APM nominal amount to encourage participation in Advanced APMs by small and/or rural practices.
- Simplify the scoring structure and reporting requirements under the Merit-based Incentive Payment System (MIPS) in order to fulfill Congress' intent of a more streamlined program that reduces burdens on physicians.

- Institute a consistent 90 consecutive day minimum reporting period across all MIPS performance categories.
- Reduce the number of measures required for full participation in the MIPS quality category from six to three measures.
- Restructure the Promoting Interoperability Category within MIPS to remove the "all-or-nothing" scoring component and provide more flexibility and options for clinicians to use their health IT to improve value-based care.

CONCLUSION

ACP appreciates the Senate Finance Committee's convening this hearing to examine the implementation of MACRA and chart the road ahead for this law in the future. We look forward to working with you to ensure that MACRA works to improve the value and quality of care delivered to patients, provides support for physicians to continue to meet performance standards measured by this new law, and additional pathways for physicians to transition into Advanced APMs.

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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 the Quality Payment Program (QPP) created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Three years into its implementation, the QPP continues to have a significant impact, not only on physicians and other 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 alternative payment models (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) 2019 Physician Fee Schedule final rule, the Centers for Medicare and Medicaid Services (CMS) estimated that as few as 16 percent of eligible clinicians will qualify for the Advanced APM track in 2021.

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.

Our detailed comments follow.

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 and underpaid services.

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 thus far, and existing models have not provided participation opportunities evenly across physician specialties. Therefore, many physicians are still exploring APMs for the first time or at only the early stages of transforming care under APM arrangements. **As a general principle, the AHA believes the APM provisions of MACRA should be implemented in a broad manner that provides**

the greatest opportunity for physicians who so choose to become qualifying APM participants. 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.

While we acknowledge and appreciate CMS's development and implementation of more APMs that qualify as Advanced APMs, we continue to be concerned that these existing and announced APMs offer too few opportunities for certain types of providers that serve more dispersed and vulnerable populations. For example, rural providers often lack the access or ability to make investments needed to participate in new models, among the many other challenges they face given their geographic location, low patient volumes, aging infrastructure in which they practice, workforce shortages and other factors. High-risk APMs are not accessible to these providers, even those that wish to participate in them. Similarly, post-acute and behavioral health providers serve particularly challenging and unique populations and thus are in need of APM options tailored to the degree of risk they can manage given their patient populations. **CMS should consider these and other providers when designing APMs and expand opportunities for them to participate in Advanced APMs that offer them targeted resources and a manageable amount of risk.**

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.

Addressing MIPS Policy Priorities

The AHA has urged 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 because of differences in clinical severity and communities they serve.

- Align the requirements for eligible clinicians in the Promoting Interoperability (formerly known as advancing care information) performance category with the requirements for eligible hospitals and critical access hospitals (CAHs).

The AHA is pleased that CMS has made important progress in addressing the above priorities. For example, in the first three MIPS performance years (calendar years (CY) 2017 through 2019), CMS has adopted gradual increases to the length of reporting periods, data standards and the performance threshold for receiving positive or negative payment adjustments. The AHA also commends CMS for using its new "Meaningful Measures" initiative to remove 26 measures from the MIPS program in the CY 2019 physician fee schedule final rule. CMS also has brought the Promoting Interoperability programs for clinicians and hospitals into far greater alignment. We offer our perspective on other MIPS policy priorities below.

Facility-based Measurement. **The AHA applauds CMS for responding to our long standing request to develop a facility-based measurement option for the MIPS that is available starting this year. We believe the option ultimately will help clinicians and hospitals alike spend less time collecting data, and more time improving care.** Under this approach, clinicians that spend 75 percent or more of their time in a hospital inpatient, emergency department (ED) setting or on-campus hospital outpatient setting can use their hospital's CMS hospital value-based purchasing program performance in the MIPS without having to report separate quality or cost data. In short, it means those clinicians and hospitals can focus their efforts on the same set of priorities, and see their performance rewarded in a consistent fashion.

Congress can help make facility-based measurement even more beneficial and effective by encouraging CMS to consider future expansion of the option to a broader array of facility types, such as post-acute care and inpatient psychiatric care providers. In last year's rulemaking process, CMS signaled an openness to expanding the option.

MIPS Cost Category. **We urge Congress to work with CMS to take a more gradual approach to increasing the weight of the MIPS cost category, as well as adding measures to the cost category.** Hospitals and clinicians alike are focused on improving the value of care and need well-designed measures of cost and resource use to help inform their efforts. However, we believe CMS's recent decision to increase the weight of the cost category to 15 percent of the total MIPS score and to adopt eight new episode-based cost measures should be delayed until CY 2022 at the very earliest.

Serious questions remain about the accuracy and reliability of all of the measures in the MIPS cost category, making it problematic to increase the weight beyond the 10 percent weight adopted for CY 2020 payments. CMS's recent changes to the Medicare spending per beneficiary (MSPB) measure underscore this point. In the CY 2017 QPP final rule, CMS chose to remove specialty adjustment from the MSPB measure, and lower the MSPB minimum volume threshold from 125 cases to just 20 cases. Yet neither of these changes had strong data or analysis to support them. Specialty adjustment in MSPB is intended to account for differences in specialty mix that can affect the costs of care. Furthermore, the MSPB measure once had a minimum case threshold of 125 cases because CMS's analyses suggested that many cases were necessary to get a statistically reliable result. We do not believe the measure materially changed in such a way that it achieves reliable results without the higher case threshold. Taken together, we worry that these measure changes will result in rewards or penalties based on differences in patient population or statistical noise, and not real performance differences.

The AHA also remains concerned that the basic performance attribution approach for the MSPB and cost per capita measures in the MIPS lacks a "line of sight" from clinician actions to measure performance. The measures do not reflect the performance of just the clinician or group practice. Rather, the measures attribute *all* of the Medicare Parts A and B costs for a beneficiary during a defined episode (three days prior to 30 days after an inpatient admission for MSPB, and a full year for total cost per capita). Yet, these costs reflect the actions of a multitude of health care entities—hospitals, physicians, post-acute providers, etc. The ability for any clinician or group to influence overall measure performance will vary significantly depending on local market factors, including the prevalence of clinically integrated networks.

Lastly, while we appreciate the concept behind the episode-based measures, we are concerned that clinicians have had limited time to understand their baseline performance and implement changes to improve performance. In contrast to the two total cost measures, the episode-based measures include only the items and services related to the episode of care for a particular treatment or condition. This measurement approach can result in a more clinically coherent set of information about cost. However, this approach also necessitates the use of algorithms for identifying costs relevant to an episode, and a multi-step approach for attributing measure performance. This methodology adds necessary rigor, but also complexity. Yet, clinicians only had information from a "dry run" of the episode measures that CMS conducted using data from 2016 before CMS added the measures to the program.

Enhancing Risk Adjustment. **Congress should encourage CMS to continue refining its approach to accounting for both clinical and social risk 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 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 methodologies for accounting for social and clinical risk continue to evolve.

Evolving MIPS in the Future

As with any significant policy change, the QPP and MIPS will need ongoing refinements to ensure it meets its goals. Indeed, that is why Congress used the Bipartisan Budget Act of 2018 to make several welcome technical amendments to the MIPS, such as allowing CMS more time to increase the weight of the MIPS cost category and applying payment adjustments to only covered professional services. These changes give providers and CMS greater flexibility, and improve the program's fairness.

Indeed, the AHA believes that future changes to MIPS policy should continue to 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 (WP) is premature. We refer the Committee to our March 2018 statement to the committee for additional information.

CONCLUSION

Thank you for the opportunity to share our views on the implementation of the 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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May 6, 2019

Hon. Chuck Grassley
Chair
U.S. Senate
Committee on Finance
Washington, DC 20510

Hon. Ron Wyden
Ranking Member
U.S. Senate
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Dear Chairman Grassley and Ranking Member Wyden,

The American Society of Clinical Oncology (ASCO) is pleased to submit comments for the Committee's hearing, "Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead."

ASCO is the national organization representing more than 45,000 physicians and other health care professionals specializing in cancer treatment, diagnosis, and prevention. We are committed to ensuring that evidence-based practices for the treatment of cancer are available to all Americans.

ASCO supported the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) as a replacement to the flawed Sustainable Growth Rate. Since its enactment, ASCO has educated its members on MACRA and how to make it work for both their practices and the Medicare beneficiaries they serve. We have extensive MACRA-related practice tools, webinars, and other resources readily available for our members on *asco.org/MACRA.*

We appreciate the Committee's shared commitment to MACRA's success, and we offer the following ideas for how Congress and the Centers for Medicare and Medicaid Services (CMS) can strengthen MACRA and the Medicare program.

Encourage the Creation of Value-Based Incentives That Increase Quality and Lower Cost

ASCO members practice in diverse settings, including community-based physician practices, outpatient cancer centers, teaching hospitals, and large cancer treatment centers. Our members participate in a variety of value-based payment models, including the Merit-based Incentive Payment System (MIPS), Alternative Payment Models (APMs) with private payers, the Center for Medicare and Medicaid Innovation (CMMI) sponsored Oncology Care Model (OCM) and other CMMI sponsored models. As strong advocates of high-quality, high-value care, ASCO has supported development of new payment models that include the full scope of services needed by patients facing a cancer diagnosis. We do not agree with piecemeal reforms based on cost alone.

A key component of OCM is the sharing of Medicare claims data, which provides physicians the information necessary to understand the total cost of care borne by Medicare and patients. Analysis of these data has highlighted opportunities to reduce health care costs. We have heard from participating practices that oncology-specific care management payments, such as OCM's monthly-enhanced oncology service (MEOS) payments, provide funding to support resources such as navigators, triage nurses, and palliative care specialists. This helps to mitigate some of the costs for these previously uncovered services that are critical to quality care in oncology. We note that, for many practices, a large portion of the MEOS payment has been consumed by administrative support needed to comply with required reporting and analysis of data. This has drawn MEOS payments away from the intended patient services support and is an area where ongoing discussion will be important.

Practices participating in APMs continue to undergo transformation. Many have reported hiring clinical and financial navigators to improve coordination of care and proactively manage symptoms that would otherwise lead to acute care admissions or other long-term expenses. Practices have also employed value-based decision support tools, such as treatment and triage pathways.

Overall, participation in these payment models have resulted in reduced admissions, improved end-of-life quality measure performance, and increased patient satisfaction.

Adopt the Patient-Centered Oncology Payment Model (PCOP)

Medicare coding and payment for outpatient cancer treatment should be transformed by adopting proposals such as ASCO's "Patient-Centered Oncology Payment Model" (PCOP) and implementing policies that are consistent with that model. Originally published in 2015, ASCO has recently convened a diverse team of clinicians, payer and employer representatives to update the PCOP model and incorporate learnings from OCM and multiple commercial payer models.

The updated PCOP incorporates a community-centric oncology medical home structure, that encourages a true multi-payer approach. The use of evidence-based clinical treatment pathways is a cornerstone of the PCOP model, along with measurement and rewards for high-quality, high-value care.

A draft of the updated PCOP model has been provided to the CMMI and will be submitted to the Physician Focused Payment Model Technical Advisory Committee later this year. Should the PTAC recommend acceptance, Congressional support will be imperative for CMMI approval. ASCO is already in discussions with states and local communities who are interested in the PCOP model to advance cancer care for their population.

Test Multiple Oncology-focused Alternative Payment Models

ASCO urges Congress to work with CMMI to create and adapt a multi-step process for developing and implementing APMs—one that begins with limited-scale testing and then refinement or expansion of promising APMs over time. ASCO believes that by utilizing small-scale testing of multiple oncology-focused APMs, CMS can highlight potentially successful strategies for the broader community of cancer patients and oncology professionals.

For cancer, ASCO urges Congress and CMS to encourage the approval of multiple APMs because of the varied needs of cancer populations and providers. Oncology practices exist in numerous forms, and a "one size fits all" approach to payment models fails to take advantage of the strength of each of these practice structures. In this context, care should be taken not to disadvantage small and rural practices, which fulfill a crucial role in oncology care. While CMS has taken concrete steps to assist small practices participating in MIPS, such as freely available technical assistance and special considerations related to their scoring in the MIPS framework, small and rural practices fared less well under MIPS in the first performance year (2017): while the overall national mean score for a clinician was 74 points, clinicians in small and rural practices had national means of 43 points and 63 points, respectively. CMMI should embrace oncology-focused APMs that differ from the existing OCM, as well as from other existing models that are not specifically focused on cancer.

Exclude Medicare Drug Cost From Resource Use in Cancer Care

ASCO has urged CMS to exclude all Medicare Part Band D drug costs from the assessment of cost performance and refrain from increasing the weight of cost performance category in the MIPS scoring methodology until it implements a cost measurement methodology that fairly and accurately assesses resource use in cancer care.

The current cost measurement methodologies are inadequate for measuring cost performance for oncology focused providers and practices due to several unique characteristics of cancer care. Cancer is a complex disease state with multiple forms. Treatment decisions are highly dependent upon a patient's unique medical characteristics, including their cancer morphology, cancer stage, genetic characteristics, mutation status, comorbidities and preferences. Individual physicians often specialize in treating specific types of cancer that may be especially complex or expensive to treat. Protecting the most vulnerable Medicare beneficiaries will require CMS to account for these considerations without threatening the viability of subspecialties that focus on treating certain cancers.

Promote Interoperability

Interoperability and the free exchange of health care information are core components to realizing the potential of a value-based health care system.

ASCO commends CMS for reforming the Promoting Interoperability (Pl) performance category measures to emphasize the exchange of health information, but we remain concerned that the scoring for this category remains essentially "all or nothing," which places a heavy penalty on practices which fail to meet one of the criteria. We understand that CMS is exploring potential options to move toward more customized scoring of this category through incentives for innovative use of HIT, and ASCO would be eager to discuss our ideas for how this could be accomplished with CMS.

Despite our many steps forward in this area, oncology practitioners are still plagued by a lack of interoperability between different types of electronic medical records (EMRs) in addition to a lack of interoperability between EMRs and other forms of health information technology including electronic systems such as registries, genomic testing laboratories, and hospital laboratory information systems. These types

of technology hold great promise for improving and enhancing patient care, especially in the realm of care coordination and quality improvement. To further enhance healthcare quality, we should move with urgency towards realizing the vision of seamlessly integrated health information, easily and securely accessible to all patients.

A basic need in the field of oncology is a common, shared set of data elements used to exchange information between providers and patients. Under our CancerlinQ (CLQ®) subsidiary, ASCO is currently developing a set of "Minimal Common Oncology Data Elements" (mCODE™), an effort designed to result in a parsimonious set of consensus-developed oncology data elements necessary for critical information exchange between EHRs, for clinical care, quality reporting, and other use cases. This set of oncology data elements is envisioned by ASCO to form the basis of an initial parsimonious set of necessary data that should populate all electronic health records (EHRs) serving patients with cancer. Adoption of these data elements, which are being developed by experts in the fields of oncology and informatics, would greatly streamline the exchange of basic needed data necessary for oncologists. The National Cancer Institute (NCI) is engaged with this project, and we look forward to collaborating with agencies such as ONC wherever possible to encourage consideration and adoption of these elements when they are finalized. We have previously provided ONC with our description of this work and will continue to keep the agency abreast of our efforts; we are currently engaged in a pilot project with a large healthcare system as proof of concept in anticipation of wider adoption of these oncology data elements, which we believe would streamline communication between care providers and positively impact patient care.

Encourage Adoption of High-Quality Clinical Pathways

ASCO strongly supports the utilization of high-quality value-based oncology clinical pathways. As health care payment models continue to advance, private insurers have already embraced the use of oncology clinical pathways that incorporate both evolving scientific evidence and considerations of cost and value. We have encouraged the Medicare program to adopt high-quality value-base d pathways as a mechanism to assure high-quality and high-value care for the Medicare population.

Clinical pathways are regularly updated treatment protocols that map care based on current scientific evidence. When used appropriately, high-quality pathways can reduce unwarranted variations in care and focus resources on the most appropriate and valuable therapies while still allowing for justifiable individualized decision-making. Placing adherence to clinical pathways at the center of an oncology-based care model can improve quality, efficiency, and value of medical oncology services for Medicare beneficiaries, and would align Medicare policy with ongoing pathway initiatives in use by commercial payers.

ASCO has done extensive work examining pathways in oncology and has developed robust criteria for the development and implementation of pathway programs. ASCO has used these criteria to assess clinical pathway vendors. For more information on clinical pathways please visit: *https://www.asco.org/practice-guidelines/cancer-care-initiatives/clinical-pathways.*

Improve Access to Claims Data

MACRA required CMS to make its data easier to access, especially for the purpose of linking clinical registries to CMS claims data. CMS is using its existing ResDAC process instead, which is cumbersome, time consuming to navigate, and strictly limits its use of the data. CMS should allow much easier access to its data, as intended by Congress in the MACRA legislation. Congress should work with CMS to ensure these changes are made.

Thank you for your commitment to improving the Medicare program. If you have questions on any issue involving the care of individuals with cancer or would like to be directed to ASCO's thoughts on a specific issue related to drug pricing, please contact Jennifer Brunelle at Jennifer.brunelle@asco.org.

Sincerely,

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

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Statement of Michael Bindner

Chairman Grassley and Ranking Member Wyden, thank you for the opportunity to comment on this issue. We will leave it to the Administration witnesses to address MACRA Implementation and confine ours comments to the Road Ahead, specifically the how Medicare for All will impact these reforms

Under Medicare for All proposals, it is assumed that insurance rates and copayments will be reduced to Medicare levels. Payments to Physicians will continue under Medicare rates, presumably relying on current reforms, such as MACRA, to help control the funding gap, with some kind of payroll or value added tax replacing premium payments, regulation of monopolistic hospital chains as public utilities, including negotiations to control both hospital and drug prices.

Monopoly and monopsony power already control costs to increase profit to shareholders. Negotiation will aim to reduce these profit margins. Please see our attachment which excerpts previous comments from last year on Medicare Advantage, including a more detailed exploration of Medicare for All.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Attachment One—Hearing on the Medicare Advantage Program

Medicare for All, Do We Already Have It?

Medicare for All is a really good slogan, at least to mobilize the base. One would think it would attract the support of even the Tea Partiers who held up signs saying "Don't let the government touch my Medicare!" Alas, it has not. This has been a conversation on the left and it has not gotten beyond shouting slogans either. We need to decide what we want and whether it really is Medicare for All. If we want to go to any doctor we wish, pay nothing and have no premiums, then that is not Medicare.

There are essentially two Medicares, a high option and a low one. One option has Part A at no cost (funded by the Hospital Insurance Payroll Tax and part of Obamacare's high unearned income tax as well as the general fund), Medicare Part B, with a 20% copay and a $135 per month premium and Medicare Part D, which has both premiums and copays and is run through private providers. Parts A and B also are contracted out to insurance companies for case management.

The other option is the Medicare Advantage (Part C) HMO. You pay a premium and copays, but there is much more certainty, while ABD are more like a PPO, but costs can go much higher. So much higher that some seniors and the disabled get Medicap coverage for the copays. Which is high and which low, I am not sure. They are both now managed care.

Medicaid lingers in the background and the foreground. It covers the disabled in their first two years (and probably while they are seeking disability and unable to work). It covers non-workers and the working poor (who are too poor for Obamacare) and it covers seniors and the disabled who are confined to a long-term care facility and who have run out their assets. It also has the long term portion which should be federalized, but for the poor, it takes the form of an HMO, but with no premiums and zero copays.

Obamacare has premiums with income-based supports (one of those facts the Republicans hate) and copays. It may have a high option, like the Federal Employee Health Benefits Program (which also covers Congress) on which it is modeled, a standard option that puts you into an HMO. The HMO drug copays for Obamacare are higher than for Medicare Part C, but the office visit prices are exactly the same.

What does it mean, then, to want Medicare for All? If it means we want everyone who can afford it to get Medicare Advantage Coverage, we already have that. It is Obamacare. The reality is that Senator Sanders wants to reduce Medicare copays and premiums to Medicaid levels and then slowly reduce eligibility levels until everyone is covered. Of course, this will still likely give us HMO coverage for everyone except the very rich, unless he adds a high-option PPO or reimbursable plan.

Either Medicare for All or a real single payer would require a very large payroll tax (and would eliminate the HI tax) or an employer paid subtraction value-added

tax (so it would not appear on receipts nor would it be zero rated at the border, since there would be no evading it), which we discuss below, because the Health Care Reform debate is ultimately a tax reform debate. Too much money is at stake for it to be otherwise, although we may do just as well to call Obamacare Medicare for All and agree to leave it alone.

Social Insurance

It is always important to note that the whole purpose of social insurance, including Medicare, is to prevent the imposition of unearned costs and payment of unearned benefits for not only the beneficiaries, but also their families. Cuts which cause patients to pick up the slack favor richer patients, richer children and grandchildren, patients with larger families and families whose parents and grandparents are already deceased, given that the alternative is higher taxes on each working member. Such cuts would be an undue burden on poorer retirees without savings, poor families, small families with fewer children or with surviving parents, grandparents and (to add insult to injury) in laws.

Recent history shows what happens when benefit levels are cut too drastically. Prior to the passage of Medicare Part D, provider cuts did take place in Medicare Advantage (as they have recently). Utilization went down until the act made providers whole and went a bit too far the other way by adding bonuses (which were reversed in the Affordable Care Act).

Funding Levels and Premium Increases

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care—with inadequate funding and quality being related. One form of increased funding could very well be higher Part B and Part D premiums (or Part C). This has been suggested by both the Fiscal Commission and the Bipartisan Policy Center. In order to accomplish this, however, a higher base premium in Social Security would be necessary. Our proposal is that to do this, the employee income cap on contributions should actually be lowered to decrease the entitlement for richer retirees while the employer income cap is eliminated, the employer and employee payroll taxes are decoupled and the employer contribution credited equally to each employee at some average which takes in all income. If a payroll tax is abandoned in favor of some kind of consumption tax, all income, both wage and non-wage, would be taxed and the tax rate may actually be lowered.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax—which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding), regardless of whether Part B and D premiums are adjusted. If the same consumption tax pays both retirement income and government health plans, the impact on the taxpayer is exactly nil in the long term.

Funding Options Through Tax Reform

We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so we will confine our remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Subtraction Value-Added Tax (VAT).

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border—nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal—covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

If employer-provided care to retirees is not included, the best funding mechanism is a Value-Added Tax with border adjustment, but at a higher rate to cover the loss. The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The NBRT can provide an incentive for cost savings if we allow employers to offer services privately to both employees and retirees in exchange for a substantial tax

benefit, either by providing insurance or hiring health care workers directly and building their own facilities. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed.

This proposal is probably the most promising way to arrest health care costs from their current upward spiral—as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the midrange of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets.

Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages—although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

HEALTHCARE LEADERSHIP COUNCIL

May 8, 2019

The Honorable Chuck Grassley
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Grassley and Ranking Member Wyden:

As the Senate Committee on Finance holds a hearing on, "Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead," the Healthcare Leadership Council (HLC) welcomes the opportunity to share its perspectives with you.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC—hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies—advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

HLC has long supported a shift away from fee-for-service healthcare toward a system based on providing better value for healthcare consumers. Our member organizations have been proponents of delivery system innovations that are value-based, patient-centered and reward improved quality and cost-effective care.

HLC strongly supported the "Medicare Access and CHIP Reauthorization Act (MACRA) of 2015" and is pleased to provide feedback that we expect will strengthen the broader transition to a payment system that emphasizes value. As providers in the delivery system transition to a new payment system that emphasizes value, we encourage prioritizing consumer feedback and outreach, provider feasibility and minimizing new administrative burdens. We have been pleased to see significant action on key recommendations provided by HLC in previous years.

In particular:

- HLC supports CMS's recognition of Medicare Advantage (MA) as an advanced alternative payment model. In payment years 2019 and 2020, the participation criteria for Advanced APMs were only for traditional Medicare payments or patients. Starting in payment year 2021, the participation requirements for Advanced APMs may include MA plans. The demonstration would allow physicians that participate in value-based arrangements with MA plans to see the same payment benefits as physicians participating in one of the CMS designated Advanced Alternative Payment Models (AAPMs).
- HLC encourages Congress and the Administration to continue to push forward with its efforts to facilitate the movement of organizations to pay-for-performance and AAPMs. A critical element of this effort will be incorporating complementary value-based arrangements (such as Medicare Advantage) into AAPM MACRA thresholds as soon as possible.
- HLC strongly supports efforts to reduce the quality measure reporting burden on clinicians. HLC continues to emphasize that this flexibility is necessary as it may be difficult—particularly in the initial years—to design APMs that are attractive to a variety of providers. The federal government must ensure, however, that these flexibilities do not lessen important incentives for provider participation.
- HLC supports the creation of a new improvement activity for clinician leadership in clinical trials, research alliances, or community-based participatory research (CBPR)—especially around minimizing disparities in healthcare access. HLC supports this effort to improve clinical trial enrollment and encourages the federal government to consider including other physicians or even a counseling service payment to incentivize providers to provide information on clinical trials.

As shared in previous correspondence, HLC continues to emphasize several broader priorities that we believe are critical for the overall success of value-based care programs.

Congress should adopt changes to modernize the federal fraud and abuse legal framework to facilitate stronger provider performance in the Merit-based Incentive Payment System (MIPS) measurement categories and facilitate growth into full AAPMs. Modernization of the current legal framework is needed to make it more compatible with healthcare delivery system transformation while retaining appropriate protections against fraud and abuse. Congress should amend the Anti-Kickback Statute and Stark Law to allow waivers for stakeholders engaged in alternative payment arrangements (both AAPMs and MIPS reporting APMs) that meet certain conditions. The current unpredictable and burdensome system of "one-off" waivers is not sufficient for alternative payment goals. Congress should also extend existing Anti-Kickback Statute and Stark Law exceptions for donation and financial support of electronic health information products that facilitate care coordination, cybersecurity protection, and compliance with systems' interoperability goals.

Quality measurement and coding updates should better incorporate socioeconomic status adjustments to incentivize alternative payment arrangements in areas of high need. It is critical that all efforts to move to outcome-based payment properly account for complexities of patients as well as the socioeconomic challenges that providers face in caring for patients. Without these adjustments, efforts to reward higher performing providers may result in lower funding for those serving the most vulnerable. To ensure appropriate payment and risk-adjustment, quality programs under MACRA should include a reasonable number of measures that effectively capture variance in patient populations. We support the use of a limited number of standard, vetted measures and urge CMS to synchronize measures, expectations, and reporting requirements with existing efforts in the private sector. By working closely with experts in the private sector, a system that appropriately reflects health system challenges—such as the social and economic status of consumers—can create a more accurate payment system.

Traditionally, ICD–10 codes are used to document diagnoses, symptoms, treatment, and procedures into the patient medical record. The expansion of these codes to include social determinants of health, including socioeconomic status, education, geographic location, home environment, functional limitation, employment, access to healthcare, transportation, food and nutrition, social isolation and many more broad categories would allow physicians to better assess the whole patient. Further, healthcare providers would be able to use these codes to document when a patient may benefit from a social service such as better access to transportation or access

to nutrition services. For example, if a patient does not have a means of transportation or cannot afford to pay for transportation to a breast cancer screening center, the probability is high that this screening will not occur. The implementation of new ICD–10 codes for social determinants of health would help manage these types of situations to drive better patient engagement, care, and outcomes.

It is imperative that Congress and CMS continue to work closely with private-sector health leaders during MACRA implementation. The law provides CMS with an unprecedented ability to transform healthcare delivery through incentives. These changes, which will have far-reaching and significant effects on consumers nationwide, should be validated by healthcare experts across the healthcare system. These changes must be deliberate, transparent, and allow for meaningful collaborative efforts. Similarly, we urge the federal government to provide clear, concise, and actionable feedback on a timely and regular basis to allow providers to improve the quality of care delivered to patients and enhance program performance.

Thank you for examining this important issue and please feel free to reach out to Tina Grande, Senior Vice President for Policy, at (202) 449-3433 or tgrande@hlc.org with any questions.

Sincerely,

Mary R. Grealy
President

MEDICAL GROUP MANAGEMENT ASSOCIATION

The Medical Group Management Association (MGMA) commends the Senate Finance Committee for convening this hearing on "Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead." MGMA is the premier association for professionals who lead medical practices. Since 1926, through data, people, insights, and advocacy, MGMA empowers medical group practices to innovate and create meaningful change in healthcare. With a membership of more than 45,000 medical practice administrators, executives, and leaders, MGMA represents more than 12,500 practices of all sizes, types, structures, and specialties that deliver almost half of the healthcare in the United States.

Through repealing the problematic sustainable growth rate and retiring an overly complex and duplicative hodgepodge of quality reporting programs, the Medicare Access and CHIP Reauthorization Act (MACRA) charted a value-based trajectory for the Medicare payment system by valuing innovative, patient-centric, and efficient care delivery over check-the-box bureaucracy.

We appreciate this Committee's oversight efforts to ensure successful implementation of MACRA's sweeping payment reforms. We also applaud Congress for making technical corrections to MACRA through the Bipartisan Budget Act of 2018, another example of its continued support for the innovative care delivery improvements taking place in physician group practices across the country.

Since MACRA passed, MGMA has partnered with Congress and the Administration to help practices succeed in the Quality Payment Program (QPP). We have hosted numerous educational events that connect our members directly with Centers for Medicare and Medicaid Services (CMS) staff, developed informational and educational resources related to the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs), and provided suggestions on how to improve the current program to policymakers based on feedback from our members.

At this critical juncture in Medicare's transition from fee-for-service toward value-based reimbursement, Congress has an opportunity to make refinements to the program that would align it more closely with the original intent of MACRA. We hope these comments will help guide the Committee as it seeks to improve the QPP, align it more closely with congressional intent in MACRA to improve physician payment, and ensure a successful transition to a new Medicare payment system centered around high-value care.

Continue the 0.5 Percent Medicare Payment Update Beyond CY 2019

MACRA stabilized annual updates under the Physician Fee Schedule (PFS) and is a vast improvement to the previous, draconian sustainable growth rate methodology. Under MACRA, PFS payment updates increased by 0.5 percent between 2015–2018, 0.25 percent in 2019, and then will be frozen for 6 years between 2020–2025.

As the healthcare community transitions toward a value-based payment environment, fee-for-service does not need to be abandoned entirely, but it does need to be updated appropriately. Physician practices face a challenging environment with escalating costs, flat reimbursement updates, and an increasingly complex regulatory environment. To continue supporting these practices as they implement the changes necessary to ensure success in new delivery models, MGMA urges Congress to continue the stability in physician payments by extending the 0.5 percent adjustment to the conversion factor beyond CY 2019.

Encourage the Development and Availability of Physician-Focused APMs

MGMA strongly supports efforts to advance value-based care delivery through APMs that reward high quality and efficient care delivery. MGMA agrees with Congress that the APM pathway is a promising door to value-based reimbursement without imposing undue administrative burden. We are encouraged by CMS' recent efforts to implement new primary care APMs through the Primary Care First and Direct Contracting models.[1]

Despite this progress, however, the healthcare system is still learning how to effectively transform care delivery. We are now past the 3-year mark for implementation of MACRA, yet there are still limited opportunities for physician practices to participate in an APM, particularly those that qualify as "advanced" under CMS regulations. CMS estimates that less than 220,000 clinicians will become qualifying participants in Advanced APMs this year, compared to the 798,000 clinicians expected to participate in MIPS.[2] Many practices are interested in joining an APM, but are unable to do so because there are not viable options for practices of their size, specialty, or location. In a 2018 survey of MGMA members, 55% of over 400 respondents reported that Medicare does not offer an Advanced APM that is clinically relevant to their practice.[3]

Congress established the Physician-focused Payment Model Technical Advisory Committee (PTAC) to leverage private sector development and expedite the availability and implementation of APMs. Dozens of APMs have been submitted to PTAC, however CMS has yet to implement or test on a limited scale any of the models recommended by PTAC. We urge Congress to direct the Administration to be more collaborative with PTAC, including testing and adopting new physician-focused payment models.

Extend the APM Bonus Beyond CY 2024 When it Currently Expires

MGMA appreciates Congress' work to support physician practices transitioning to value-based payment in Medicare by providing incentives to participate in APMs, including a five percent bonus payment for significant participation in APMs. This five percent bonus is a powerful incentive for practices to participate in APMs, but it is set to end in 2024. Momentum toward practice participation in these value-based models could be lost without this support. We urge Congress to consider extending the availability of the five percent payment to continue incentivizing practices to participate in APMs as more models are developed that may offer practices an opportunity to participate in an APM for the first time.

Furthermore, the five percent bonus is not only an incentive to participate in an APM, it also lends financial support to practices incurring extra expenses when making the transition into a new care delivery model, which may include start-up costs, hiring and training additional support staff, making technology upgrades, and the use of time and resources for high-value, yet non-covered, services.

We share Congress and the Administration's goal of expediting the process for physician practices to participate in APMs and believe an important step to achieving this goal is to extend the availability of the five percent incentive payment beyond 2024 when it is currently set to expire, so that group practices have the opportunity to receive the support Congress intended.

Modify the APM Risk Standard

We recommend modifying the APM financial risk standard to account for start-up costs as well as ongoing expenses incurred by a group practice as they participate in an APM. Start-up costs alone can easily exceed millions of dollars by CMS' own estimates, and these amounts should be counted towards an APM's nominal amount standard. Incorporating these financial risks could lead to many more APMs enter-

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[1] "HHS to Deliver Value-Based Transformation in Primary Care," HHS Newsroom (April 22, 2019).
[2] 83 Fed. Reg. 59452, 59721 (November 23, 2018).
[3] "MGMA 2018 Regulatory Burden Survey" (October 2018).

ing this track of MACRA and additional APMs finally being recognized for the very tangible risk they are assuming.

Modernize Antiquated Fee-for-Service Policies That Undercut Value-Based Transformation

As practices explore new payment models, they face outdated payment requirements and fraud and abuse rules that hinder their ability to coordinate care. To allow for greater care coordination within the construct of APMs, MGMA recommends that Congress assess and modify the existing physician self-referral (Stark Law) prohibition and/or create new waivers for APM participants from certain fraud and abuse rules and payment requirements.

There is a growing consensus supporting the expeditious modernization of existing fraud and abuse rules, such as the Stark Law and Anti-Kickback Statute (AKS). While well-intended, the Stark Law and AKS are broadly construed such that they effectively prohibit or introduce uncertainties regarding clinical and financial integration arrangements that have the potential to improve care for patients.

Congress has recognized the incongruity between the current fraud and abuse framework and the development and implementation of APMs and other value-based payment arrangements. Congress authorized the Administration to issue waivers for select programs, such as those created through the Center for Medicare and Medicaid Innovation (CMMI) and for accountable care organizations in the Medicare Shared Savings Program. Waivers do not offer sufficient protection, however, as they are issued on a case-by-case basis, are limited in duration, and only protect arrangements within specific programs. Uncertainty about the application of fraud and abuse rules, and potential for severe penalties for any violation, have had a chilling effect on innovation and slowed the progression toward cost-efficient, quality-driven models.

As the healthcare industry transitions to a value-driven payment environment, we urge Congress to enact legislation that modernizes these outdated rules and creates flexible waivers for APMs, which are already held accountable for utilization and quality of care as inherent aspects of model design. Congress should pass the Medicare Care Coordination Improvement Act (S. 966/H.R. 2282), which would expand the Secretary's fraud and abuse exception and waiver authority and remove the "volume or value" prohibition in Stark Law to facilitate the development and operation of APMs. Additionally, we support broader reforms, such as eliminating the compensation prong from the Stark Law to return its focus to governing ownership arrangements.

Lastly, we recommend the Committee reevaluate the usefulness of out-of-date billing requirements for telehealth and other high value services. This is particularly important for APMs, which are held accountable for total cost of care and should not be subject to a duplicative set of requirements.

Streamline and Simplify MIPS Reporting Requirements

As medical group practices transition to value-based payment to improve the delivery of health care, they are hamstrung by burdensome and outdated government mandates that impede innovation, drive up costs, and ultimately redirect resources away from patients. Through its oversight authority, Congress should ensure CMS does more to streamline and significantly simplify reporting requirements and scoring for MIPS. CMS should reduce the overall number of measures required for full participation in MIPS and use a flexible set of measures that are proven to be statistically reliable, clinically valid, outcomes-focused, and, most importantly, patient-centered. Furthermore, CMS should base MIPS point values for individual measures on their relative value to the total MIPS score.

Minimizing regulatory burden to the greatest extent possible, such as burdens related to quality reporting requirements, allows physician practices to allocate more time toward improving patient care. To assist CMS in resetting its approach and achieving its stated goals of reducing clinician burden in MIPS and enhancing patient care, MGMA encourages Congress to instruct CMS to make the following high-impact improvements to MIPS:

- *Decrease the number of measures across MIPS.* Physician group practices' finite resources are spread across a minimum of nearly 20 measures required to meet MIPS requirements. CMS should structure MIPS to allow practices to prioritize effective and impactful improvements to patient care, rather than comply with sprawling reporting mandates.

- *Significantly simplify the scoring scheme.* CMS should simplify the overall MIPS scoring structure by basing point values for individual measures on their relative value to the total MIPS score.
- *Increase CMS' flexibility to appropriately score MIPS performance.* On top of simplifying the overarching scoring scheme of MIPS, Congress should add legislative language to MACRA to increase flexibility in MIPS scoring methodology to expressly allow CMS to provide clinicians and group practices with credit across categories for performing certain activities that touch on multiple MIPS categories. For instance, reporting quality measures via certified EHR technology should count toward fully meeting the promoting interoperability category, rather than merely toward bonus points.
- *Do not prematurely measure cost.* Many features of the cost performance category are still unfinished. Currently, CMS is overhauling two MIPS cost measures to address longstanding, significant concerns related to flawed attribution and insufficient risk adjustment methodologies; adding new condition-based measures; and testing patient relationship codes. Group practices should not be evaluated on measures with unresolved methodological flaws. While CMS continues to fine-tune the cost component of MIPS, Congress should encourage the agency to weight the cost category to ten percent to allow sufficient time to significantly overhaul existing cost measures. CMS' own data has shown that the current methodology discriminates against physicians who treat the sickest patients. The agency needs time to develop better risk adjustment and attribution methodologies. It is crucial for CMS to understand the complexities of patient attribution and take this opportunity to fully test any new code set, such as the patient relationship codes required under MACRA, to ensure the agency achieves the desired outcome of appropriately assigning costs to providers who have control over the care.
- *Provide clear and actionable feedback about MIPS performance at least every calendar quarter,* as recommended by the statute. Without timely feedback, MIPS is essentially a reporting exercise that enters data into a "black box" only understood by CMS, rather than a useful barometer practices can leverage to drive clinical improvement.

Conclusion

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

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The Medicare Payment Advisory Commission (MedPAC) is a small congressional support agency established by the Balanced Budget Act of 1997 (Pub. L. 105–33) to provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is a Medicare program that ensures beneficiary access to high-quality, well-coordinated care; pays health care providers and health plans fairly, rewarding efficiency and quality; and spends taxpayer and beneficiary dollars responsibly. The Commission thanks Chairman Grassley and Ranking Member Wyden for the opportunity to submit a statement for the record today.

Background

Physicians and other health professionals billing under Medicare's fee schedule deliver a wide range of services—office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings. The Medicare program paid $69.1 billion for physician and other health professional services in 2017, or 14 percent of benefit spending in Medicare's traditional fee-for-service (FFS) program. In 2017, about 985,000 health professionals billed Medicare through the fee schedule—roughly 596,000 physicians and 389,000 nurse practitioners, physician assistants, thera-

pists, chiropractors, and other practitioners (Medicare Payment Advisory Commission 2019).

Medicare's fee schedule payment rates are based on the clinician work required to provide the service, expenses related to maintaining a practice, and expenses related to professional liability insurance. From 1999 to 2015, updates to these payment rates were governed by the sustainable growth rate (SGR) system, which set updates so that total spending would not increase faster than a target—a function of input costs, FFS enrollment, gross domestic product (GDP), and changes in law and regulation. Because annual spending generally exceeded these parameters, payments to clinicians were scheduled to be reduced by ever-growing amounts starting in 2002. The Congress overrode these negative cuts in all but the first year they were scheduled. Because of these overrides and volume growing in excess of per capita GDP, the resulting scheduled payment rate reduction was expected to be 21 percent in 2015, creating considerable tension for clinicians and the Medicare program. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the SGR system and created a fixed set of statutory updates for clinicians.

MACRA also included two other major provisions—an incentive payment for qualifying participants in advanced alternative payment models (A–APMs) and the Merit-based Incentive Payment System (MIPS). From 2019 through 2024, clinicians who are qualifying participants in an A–APM receive incentive payments of 5 percent of their Medicare-covered professional services revenue each year that they qualify. MACRA's incentive payments for clinicians participating in A–APMs were intended to encourage clinicians to move toward these models. A–APMs generally require participating entities to assume financial risk for their patients, which creates incentives for providers to improve care coordination and quality while controlling cost growth. Unless otherwise exempted, clinicians who are not qualifying participants in an A–APM and meet certain thresholds for Medicare participation are required to participate in MIPS. MIPS is a system that calculates individual clinician-level or group-level payment adjustments based on four areas: (1) quality and advancing care information, (2) meaningful use of electronic health records, (3) clinical practice improvement activities, and (4) cost. Based on the clinicians' performance in these four areas, the payments they receive from Medicare can be increased or decreased by varying amounts over time. The basic MIPS payment adjustments are budget neutral, but MACRA also appropriated an additional $500 million in bonuses for exceptional performance in MIPS each year from 2019 to 2024.

(The Commission has commented extensively on A–APMs and MIPS. For more background on these topics, see the Commission's annual reports and comment letters referenced at the end of this document).

The Commission Supports Repeal of the Sustainable Growth Rate System

The Commission had long supported repealing the SGR and commends the Congress for doing so (Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2018b). The SGR failed to restrain volume growth under the fee schedule and, in fact, may have exacerbated it. Although the pressure of the SGR likely minimized fee increases while in effect, it disproportionally affected clinicians who have less ability to increase volume, such as primary care providers. Additionally, both the magnitude of the threatened cuts and the temporary policies to override the SGR engendered uncertainty among clinicians, which in turn may have caused anxiety among beneficiaries. For these reasons, the Commission believes that repealing the volume-based approach to clinician payment was warranted. The MACRA approach of tying payments to clinicians' performance, through comprehensive, patient-centered care delivery models, provides better incentives for clinicians and could ideally result in better care and outcomes for Medicare beneficiaries.

Implementing Advanced-Alternative Payment Models

MACRA established the A–APM incentive payment to spur reform in the delivery of health care by encouraging clinicians to move toward these models, in which providers take accountability for health care spending and quality. A–APMs are defined in statute based on three criteria:

1. The model requires use of certified electronic health record technology.
2. The model makes payments based on a set of quality measures comparable with MIPS.
3. The model requires the entity to bear financial risk under such alternative payment model in excess of a nominal amount or to be a medical home ex-

panded under Section 1115A(c) (Medicare Payment Advisory Commission 2016b).

The Commission generally supports the establishment of A–APMs and other elements of MACRA that are designed to move clinicians toward comprehensive, patient-centered care delivery models. These models can help counter the incentives in traditional FFS, which reward volume and thus can lead to higher spending for the Medicare program and for beneficiaries. The Commission holds that it is important to encourage providers to take accountability for the cost of health care and for quality outcomes, and it has long recognized the limitations of traditional FFS.

Effective A–APMs should encourage delivery system reform that results in beneficiaries having access to high-quality health care services and a sustainable Medicare program. To help the Centers for Medicare and Medicaid Services (CMS) implement A–APMs in a way that achieves that goal, in June 2016 the Commission established the following set of principles to help inform how A–APMs should be defined (Medicare Payment Advisory Commission 2016b):

- Clinicians should receive an incentive payment only if the A–APM entity in which they participate (*e.g.,* an accountable care organization (ACO)) is successful in controlling cost, improving quality, or both.[1]
- The A–APM entity should be at financial risk for total Part A and Part B spending.
- The A–APM entity should be responsible for a beneficiary population sufficiently large to detect changes in spending and quality.
- The A–APM entity should have the ability to share savings with beneficiaries.
- CMS should give A–APM entities certain regulatory relief.
- Each A–APM entity should assume financial risk and enroll clinicians.

While the statute contains some guidance for the models CMS should consider as A–APMs for purposes of the 5 percent incentive payment, the agency has considerable flexibility in making that determination. CMS began deciding which models qualified as A–APMs beginning in 2017, and the number has increased each year to 13 models in 2019 (Centers for Medicare and Medicaid Services 2018a).

Some A–APMs align relatively well with the Commission's principles for A–APMs. One type of A–APM that the Commission has generally supported is an ACO model that features two-sided financial risk, meaning that providers share in savings or losses based on beneficiaries' actual spending relative to what was expected. The Next Generation ("NextGen") ACO model is an example. It began in 2017, and participating providers agree to take responsibility for the overall cost and quality of medical care for a population of beneficiaries. This model has strong incentives for providers to improve quality and control the overall cost of care for attributed beneficiaries, and it generally aligns with our principles. The most recent evaluation of the program found that in its first year the NextGen program reduced Medicare spending for beneficiaries by 1.7 percent before taking into account shared savings paid to the ACOs (and losses paid to Medicare by ACOs) (NORC at the University of Chicago 2018). After shared savings and losses are taken into account, the NextGen demonstration saved 1.1 percent. Most quality measures did not show statistically significant changes.

Recently the Commission conducted an analysis to measure the performance through 2016 of the Medicare Shared Savings Program (MSSP), the largest ACO program in Medicare. Almost all of the ACOs in the MSSP during this time did not face two-sided financial risk, and thus had weaker incentives than ACOs in the NextGen program. We concluded that the MSSP resulted in spending growth from 2012 to 2016 that was 1 or 2 percentage points lower than spending growth would have been without the program. However, that was before payments to ACOs for shared savings, and actual savings realized by the Medicare program were thus lower. Models incorporating two-sided risk, like NextGen, have stronger incentives for achieving better cost and quality outcomes and align most closely with our principles.

In contrast, some A–APMs do not align well with our principles. For example, the Commission has expressed concerns about the Comprehensive Primary Care Plus (CPC+) model being designated as an A–APM, in part because providers could join

[1] Clinicians are participants in A–APM entities. The A–APM entity is a participant in a qualifying model.

without assuming enough financial risk to change incentives for delivering care (Medicare Payment Advisory Commission 2016a). In CPC+, providers get additional payments in the form of monthly fees and awards based on performance. These additional dollars are intended to help primary care practices coordinate care to improve quality and reduce spending. However, participants in CPC+ only face financial risk for these additional payments, and not on their FFS revenue. The Commission has expressed concern that A–APMs with low standards for financial risk may attract providers interested in gaining the incentive payment and not in changing care delivery.

In April 2019, CMS posted performance results from the first year of CPC+. Overall, the evaluation found that practices participating in CPC+ tended to have FFS spending that was 2 to 3 percent higher than comparison practices, after accounting for enhanced payments. These results illustrate the risks to the Medicare program and taxpayers of having A–APMs that are not designed with robust incentives (Centers for Medicare and Medicaid Services 2019).

Ideas for Improving A–APMs

A key policy choice is whether to have more A–APM participants in models with weaker incentives, or fewer A–APM participants in models with stronger incentives. The Commission's goal is for Medicare to design efficient A–APMs that create real value for beneficiaries, the Medicare program, and taxpayers, not to maximize the number of providers that can join A–APMs. Thus, it is important for policymakers to continue improving A–APMs in order to increase their likelihood of success. To help in that effort, the Commission has discussed several policies that could improve A–APMs. These policies are focused on strengthening incentives for providers to change practice patterns, reducing burden and uncertainty, and sending consistent signals throughout the Medicare program for how providers and other entities will be measured on cost and quality.

Maintain High Standards for Financial Risk

CMS should only approve A–APMs with high standards for financial risk. As noted above, without high standards for financial risk, A–APMs may attract providers who see the model primarily as a means for gaining incentive payments, and who may be less focused on changing care delivery. This would increase spending for the Medicare program and beneficiaries, without providing real value.

Use Prospective Attribution in ACOs

Starting in June 2019, MSSP ACOs (some of which are A–APMs) will be given the ability to choose, each year, whether to have their beneficiaries assigned prospectively or retrospectively. This creates risk for the program because it could encourage patient selection. Prospective assignment means that beneficiaries are assigned to an ACO based on which providers they saw in the previous year. Retrospective assignment means that beneficiaries are assigned to an ACO based on the providers they saw in the current year. There are strengths and weaknesses to both approaches, but, on balance, prospective assignment has several advantages. ACOs know with certainty who their assigned beneficiaries are at the beginning of the year, and thus can better target their efforts to improve care. Also, when an ACO knows in advance who its beneficiaries are, the program is able to relax regulations and give greater flexibility to the ACO (*e.g.,* by allowing a waiver from the requirement that a beneficiary have a 3-day hospital stay before being admitted to a SNF). Prospective assignment also reduces problems of patient selection that may arise through retrospective assignment. Under retrospective assignment, ACOs can take actions during a performance year to influence which patients are assigned to them. For example, toward the end of the year, an ACO could encourage patients with little service use to have an annual wellness visit (AWV) with an ACO clinician so that low-spending patients would be assigned to the ACO. Alternatively, an ACO could encourage patients to see non-ACO doctors if they have an anticipated need for an expensive procedure such as a knee replacement. These selection issues are less of a problem under prospective assignment because it is more difficult to predict a patient's spending in a future year than in the current year, and the ACO is responsible for the patient's spending during the entire year regardless of where the patient gets care.

Measure Quality Consistently Across Medicare

To reward accountable entities and providers for offering high-quality care to beneficiaries, A–APMs should be designed to link payment to quality of care. However, the ACO program used 32 quality measures in 2018, including some process measures with an unclear link to patient health outcomes. Using so many measures is

burdensome to ACO participants and makes it difficult to draw comparisons with providers in other parts of Medicare that use different quality measures. The Commission asserts that Medicare quality incentive programs should use a small set of outcomes, patient experience, and value measures to assess the quality of care across different populations, such as beneficiaries enrolled in Medicare Advantage (MA) plans, ACOs, and FFS in defined market areas, as well as those cared for by specified hospitals, groups of clinicians, and other providers (Medicare Payment Advisory Commission 2018a).

A consistent set of population-based measures will allow policymakers to compare quality across different accountable entities and providers in the Medicare program. This would also provide information to the program to better reward high-quality providers, and to beneficiaries to inform decisions of where to get care. Sending consistent signals across the program could also help providers focus their quality improvement activities on improving patient outcomes.

Continue Improving FFS

Although A–APMs represent a significant opportunity to encourage delivery system reform and to move the Medicare program to paying for value, it is important to remember that these payment models largely rely on the Medicare FFS system to operate underneath them. That is, in most A–APMs, providers still submit FFS claims and are paid FFS rates. Therefore, it is crucial that the FFS payment systems be continually maintained and improved so that they function smoothly and, to the extent possible, do not create conflicting incentives.

Moving Beyond the Merit-based Incentive System (MIPS)

MedPAC shares Congress's goal, expressed in MIPS, of having a value component for clinician services in traditional Medicare that promotes high-quality care. However, MedPAC believes that MIPS, as currently structured, cannot achieve this goal and, therefore, should be replaced with a better quality payment program (Medicare Payment Advisory Commission 2018b). The Commission did not reach this conclusion hastily. We first examined options for improving MIPS as it was implemented, and we have provided feedback as CMS established rules for the first three years of the program (Medicare Payment Advisory Commission 2016a, Medicare Payment Advisory Commission 2017). However, as we continued to explore MIPS in a deliberative process laid out in several Commission reports to the Congress, we came to the conclusion that the basic design of MIPS is fundamentally flawed. For a number of reasons, MIPS will not succeed in helping beneficiaries choose clinicians, in helping clinicians change practice patterns to improve value, or in helping the Medicare program reward clinicians based on the value of the care they provide.

First, information collected under MIPS is unlikely to be meaningful because the MIPS measures are variable in application, clinical appropriateness, and association with meaningful outcomes. Under MIPS, each clinician's quality score is based on six measures chosen by the clinician from a set of several hundred predominantly process measures. To measure all or most medical and surgical specialties at the individual level, as the MIPS program is designed, there needs to be a wide variety of clinical process measures, including those relevant to each specialty. Therefore, when clinicians are compared with each other nationally to determine Medicare payments, the comparison is on wholly different measures. This will likely lead to substantial inequities over time and to the ultimate rejection of the program as unfair. The Commission supports providers using additional measures, such as care process measures, to manage their own quality improvement. However, these measures should not be tied to Medicare payments through quality incentive programs.

Second, few individual clinicians manage a sufficient number of discrete beneficiary medical issues and resultant processes of care during a year to produce reliable, statistically significant comparative results (the "small numbers" problem). Although some clinicians may furnish services at volumes large enough to be accurately measured, they are too few to build a comprehensive program that is broadly accurate and equitable across clinicians. In the third year of the program, CMS plans to exclude about 45 percent of clinicians from the MIPS program because they do not meet group eligibility or fall below the low-volume threshold (Centers for Medicare and Medicaid Services 2018b).

Third, adjusting payment based on quality and efficiency measured at the individual clinician level belies the reality of modern medicine. Medicine is increasingly provided by care teams. Although there are clearly examples of how the actions of one clinician alone are critically important to quality outcomes, the preponderance of care experienced by most Medicare beneficiaries is the result of the actions of mul-

tiple clinicians and institutions. The Commission believes that coordinating care over time and across settings is one important key to a more effective and efficient Medicare program of the future. Measuring clinicians individually and on their own chosen measures undermines incentives to coordinate care broadly across the Medicare program.

Fourth, requiring clinicians to report annually multiple measures to CMS is burdensome, complex, and expensive. For 2017 (the first year of reporting under MIPS), CMS estimated that the cost for providers to comply with MIPS was more than $1.3 billion (Centers for Medicare and Medicaid Services 2016). CMS estimated that MIPS would require approximately $700 million in reporting costs in 2018 (Centers for Medicare and Medicaid Services 2017). For 2019, CMS did not provide a summary estimate for reporting costs (Centers for Medicare and Medicaid Services 2018b). Clinicians have already spent a substantial amount of financial resources and time to implement MIPS, and they will continue to do so. This is time and money that could be better devoted to patient care.

MIPS Is Not Succeeding

Based on the flaws in the design of MIPS, we expected that MIPS-based payment adjustments would be small in the first years of the program, providing little incentive for clinicians to improve. This expectation was confirmed by CMS's first year MIPS performance data, which showed that the maximum MIPS bonus a clinician receives in 2019 is 0.22 percent. When the exceptional performance bonus is added, the maximum total bonus is 1.88 percent.

Almost all (93 percent) of clinicians who participated in MIPS are receiving a small positive adjustment in 2019 based on their 2017 performance (Medicare Payment Advisory Commission 2019). Seventy-one percent of the clinicians qualified for a positive adjustment plus an exceptional performance bonus. CMS estimates that this trend will continue in payment year 2021, with about 90 percent of participating clinicians receiving a MIPS bonus and about 60 percent receiving an additional exceptional performance bonus (Centers for Medicare and Medicaid Services 2018b). Most participating clinicians receive a positive payment because of a number of policy decisions CMS has made to reflect a phased approach to MIPS implementation, which CMS refers to as "Pick Your Pace." Specifically, CMS used its regulatory authority to:

- Set the MIPS performance threshold at 3 points (out of 100) for payment year 2019. Clinicians with a score above 3 are to receive a neutral or positive payment adjustment, and clinicians with a score of 3 or below are to receive a negative payment adjustment. For payment year 2021, CMS has changed the performance threshold from 3 to 30 points.
- Set the MIPS exceptional performance bonus threshold at 70 points (out of 100) for payment year 2019 and 75 points for payment year 2021.
- Permit clinicians to meet the 3-point MIPS performance threshold by reporting minimal information on one quality measure (or attesting to one performance activity) in 2019.
- Weight the cost component at 0 points, so costs (*i.e.,* resource use) do not affect MIPS payment adjustments in the first year. Costs account for 15 percent of the total performance score in year 3.

Because clinicians could choose which measures to report, most clinicians had very high performance scores overall in the first year of the program. Specifically, the mean performance score was 74 points, and the median performance score was 89 points, well in excess of the 3-point threshold for a positive adjustment and the 70-point threshold for the exceptional performance bonus.

Under the statute, performance thresholds will eventually be set at the mean or median of clinician performance, and payment adjustments will increase substantially to ±9 percent. Because clinicians will still be able to select the measures on which they expect to perform well, MIPS scores will continue to be very high and compressed around a high average. This means that small changes in scores will result in very large and unpredictable swings in payment adjustments, creating greater uncertainty and inequity, and potential rejection of the program by large numbers of clinicians.

The MIPS program is not succeeding in its goals of rewarding and penalizing clinicians based on performance. Subsequent legislation has delayed implementation of the higher performance thresholds to 2022. The Commission urges policymakers to

use the intervening years to begin developing an alternative approach to measuring and rewarding value in clinician payment.

A New Direction for Rewarding Clinician Quality: A Voluntary Value Program

While the Commission believes MIPS is fundamentally flawed, we do believe that traditional Medicare FFS clinician payment should have a value-based payment component. Thus, we also recommended creating a new clinician value-based purchasing program—a voluntary value program, or VVP—to take its place (Medicare Payment Advisory Commission 2018b). The VVP recommendation reflects a conceptual direction (not yet a detailed design) for rewarding clinician quality in FFS Medicare according to the core quality principles developed by the Commission; future Commission work will explore more detailed specifications for a VVP.

The VVP would incorporate the Commission's quality measurement principles by measuring groups of clinicians (rather than individual clinicians, to address the "small numbers" problem) on a small set of population-based metrics—that would include measures such as readmission to the hospital and patient experience—that are important to the program and its beneficiaries, can be measured reliably, and can be applied across payment models and providers (Medicare Payment Advisory Commission 2018a). These types of measures would recognize that all clinicians have a role in affecting the health outcomes of their patients. The data required to calculate the measures would be generated from claims or surveys, substantially reducing clinicians' reporting burden. Moreover, this approach aims to align measures for clinicians with measures we have suggested CMS use in its other quality programs, creating the potential to send clear, transparent, and consistent signals to providers in all sectors. Participation in the program would be voluntary, and clinicians would elect their own group (*e.g.,* independent practice associations, organized hospital medical staffs, or local medical societies), which could include specialists as well as primary care clinicians.

The VVP would encourage clinicians to think about how the care they provide contributes to the overall health outcomes of their patients, while also providing a transition for those who want to join A–APMs. This new direction would encourage care coordination among clinicians, focus quality improvement efforts on measures that are important to beneficiaries and Medicare, and relieve individual providers of the significant reporting burdens they face today and in the future. The VVP would also make quality measurement more equitable across different types of clinicians and improve the transparency of clinician quality of care for both the Medicare program and its beneficiaries.

Conclusion

MACRA made important improvements in how Medicare pays for clinician services. The Commission commends the Congress for repealing the SGR, which created uncertainty in Medicare payment for many years and contained poor incentives that rewarded volume of services. The Commission supports the elements of MACRA that move toward comprehensive, patient-centered care, including the establishment of A–APMs. However, the Commission urges the Congress to move past MIPS, as it will not accomplish the shared goal of motivating providers to improve performance on cost and quality. The Commission looks forward to continuing to be a resource for the Committee as it deliberates on policies to promote high-quality clinician care at lower costs to beneficiaries and the program.

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We thank the committee for their work on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and for continuing to ensure the proper implementation of this landmark legislation. We appreciate the opportunity to provide comments on the recent Committee on Finance hearing, "Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead."

The National Association of ACOs (NAACOS) is the largest association of accountable care organizations (ACOs), representing more than 5 million beneficiary lives through 330 Medicare Shared Savings Program (MSSP), Next Generation Model, and commercial ACOs. NAACOS is an ACO member-led and member-owned nonprofit working on behalf of ACOs across the nation to improve the quality of Medicare, population health, outcomes, and healthcare cost efficiency. Our members want to see an effective, coordinated, patient-centric care process.

The ACO model is a market-based solution to fragmented and costly care that empowers local physicians, hospitals, and other providers to work together and take responsibility for improving quality, enhancing patient experience, and reducing waste. The number of ACOs in Medicare has grown considerably in recent years and included nearly 650 ACOs in 2018, covering 12.3 million beneficiaries. ACOs have been instrumental in the shift to value-based care and utilize cost-saving tools like telehealth to better reach their patient populations.

Therefore, we feel it is critical that Congress continue to guide the effective implementation of MACRA and the Quality Payment Program (QPP) by strengthening the role of Alternative Payment Models (APMs) as a key piece of the transition to a value-based payment system. As the premier APM, ACOs are focused on population health for the totality of patients they serve. We therefore urge Congress and the Centers for Medicare and Medicaid Services (CMS) take steps to ensure that the ACO program remains a robust, successful participation option for Medicare providers navigating both value-based care and MACRA. Our specific recommendations are as follows:

Quality Payment Program Recommendations

1. Extend the Advanced APM 5% Bonus for an Additional 6 Years

Eligible clinicians who participate in an Advanced APM [1] and meet certain Qualifying APM Participant (QP) criteria will receive a 5% annual lump sum bonus from 2019–2024. Under the current statute, after 2024, that bonus expires and QPs will instead only receive a 0.75% increase in Medicare Part B payments.[2]

While CMS projections of the number of eligible clinicians that meet the QP criteria have increased with each year of the program, the number remains low. In fact, the number is lower than Congress envisioned in 2015 when MACRA was passed; in a 2015 CMS Office of the Actuary report, published shortly prior to the passage of MACRA; that office asserted that 60 percent of physician payment would be through Advanced APMs by 2019. The reality has been much slower: in the first year of the QPP, CY 2017, CMS predicted between 9–16% of all eligible clinicians to become QPs. For the third year of the QPP, CY 2019, CMS estimates that between 17–21% of eligible clinicians will be QPs. Given the slow implementation of Advanced APMs, we urge the extension of the 5 percent Advanced APM bonus for an additional 6 years to encourage adoption.

2. Lower or Remove the QP Thresholds

To become a QP, an eligible clinician must receive at least SO percent of their Medicare Part B payments or see at least 35 percent of Medicare patients through an Advanced APM entity at one of three determination snapshots during the year. In addition, 75 percent of practices need to be using certified EHR Technology within the Advanced APM entity. While certain eligible clinicians may also become a QP through the "All-Payer and Other Payer Option," which is a combination of Medicare and non-Medicare payer arrangements such as private payers and Medicaid, this option has not been widely utilized. The current and future QP thresholds are challenging for providers to meet, resulting in less participation in Advanced APMs. Many providers already have difficulty meeting the current percentage threshold, which increased in performance year 2019. The 75 percent threshold that goes into effect for performance year 2021 is far too high for continued widespread and meaningful participation and will undoubtedly preclude many providers from obtaining QP status. To continue to increase participation in Advanced APMs, we urge Congress to modify the statutory QP thresholds such that CMS has discretion to set thresholds OR modify the payment amount threshold to be set at a lower level.

3. Address APM Overlap

As more APMs are rolled out, APM overlap within markets and provider organizations has occurred more frequently, and we have observed confusion in the marketplace regarding which APMs providers may participate, and when. While some APMs can complement one another when it comes to improved quality and other outcome-based goals, participation in more than one APM can result in conflicting financial incentives that undermine the objectives of those already in existence. APM overlap also adds administrative complexity and dilutes the savings opportunities for those already on the forefront of care redesign.

To address APM overlap, we recommend:

i. An independent review of all CMS APMs and how they overlap with one another, and a subsequent report back to Congress about APM overlap and how the agency is mitigating concerns related to overlap such that APMs support one another rather than conflict.

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[1] CMS identifies qualifying Advanced APMs annually. In 2019, CMS has identified 13 AAPMs. See CMS, "Advanced Alternative Payment Models (APMs)," available at *https://qpp.cms.gov/apms/overview*.

[2] The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Pub. L. 114–10(a)(2)(C)(20), enacted April 16, 2015.

ii. CMS should be required to address how model overlap will work with each release of a new model. A market-driven approach should be prioritized, establishing methods for APMs to work together.

iii. CMS should be permitted to allow multiple program participants to keep the shared savings they have earned regardless of the existence of program overlap in instances where at least one of the programs is being tested by the Center for Medicare and Medicaid Innovation, under 1115A of the Social Security Act.

4. Modify the All-Payer Combination Option

The All-Payer Combination Option takes into account an eligible clinician's participation in Advanced APMs both with Medicare and other payers (including Medicare Advantage, Medicaid, and other commercial plans) when determining whether the eligible clinician meets the QP threshold. The All Payer Combination Option allows eligible clinicians to become QPs through participation in a combination of Advanced APMs and Other Payer Advanced APMs starting in the 2019 QP Performance Period. We recommend modifying the All-Payer Combination Option to be a Multi-Payer Combination Option to allow for increased participation of this option.

As currently structured, CMS requires providers to submit detailed information on *all* payers with which they have contracts. While there are an increasing number of opportunities to work with payers outside of Medicare on value-based arrangements, many payers do not yet offer APMs that meet CMS's definition of an Advanced APM. Accordingly, providers do not have ample opportunity to receive additional credit for their participation with those payers that do offer Advanced APMs. Effectively, being required to submit information on all payers, regardless of whether they offer Advanced APM opportunities, waters down Advanced APM participation with those that do offer Advanced APMs. We do not believe Congress's intent was to structure the All-Payer Combination Option in this manner, which does not meaningfully reward Advanced APM participation outside of Medicare. CMS has explained that the statutory language does not allow them to provide credit for Advanced APM participation with some payers while not factoring in payers that do not offer Advanced APM arrangements.

To remedy this problem, we urge Congress to modify the statute to base the All-Payer Combination Option on multiple payers without making providers have to meet a more difficult "All-Payer" threshold. This modification would change the All-Payer Combination Option to be additive in a way that it could only help APM entities meet QP thresholds when the entity is unable to do so strictly through Medicare APM participation.

5. Exclude MIPS Payment Adjustments From ACO Expenditures

NAACOS also continues to oppose the unfair policy whereby CMS counts MIPS payment adjustments as ACO expenditures. The current framework CMS has established will punish ACOs for their high performance in MIPS. NAACOS believes CMS should recognize all ACOs, including those in BASIC tracks, as Advanced APMs. However, because CMS continues to subject BASIC track Level A, B, C, and D ACOs to MIPS, these ACOs have no choice but to be evaluated under MIPS while continuing their focus on the ACO program goals. Most ACOs will perform very well under the established MIPS performance criteria and therefore earn bonuses under the program. These bonuses will then count against the ACO when expenditures are calculated for purposes of MSSP calculations. Therefore, the better an ACO and its clinicians perform in MIPS, the more they will be penalized when calculating shared savings for the ACO. This is an unfair and untenable policy, and CMS must modify its position to exempt MIPS payment adjustments as expenditures in the ACO program. CMS does make claim level adjustments by adding sequestration costs back to paid amounts when calculating ACO expenditures, therefore the Administration has the technical ability to make such a change. It was not the intent of Congress to penalize ACOs in MIPS, and therefore CMS must alter this policy to continue encouraging provider participation in the BASIC track of the ACO program. Therefore, we urge Congress to work with CMS to revise this flawed policy.

6. Discontinue Delays to MIPS Implementation

NAACOS is concerned that Congress and the Administration continue to make changes to MACRA to further dilute accountability for quality and cost performance for Medicare beneficiaries. In the Bipartisan Budget Act (BBA) of 2018, Congress provided CMS with additional flexibility to implement the performance standard for which clinicians were intended to be evaluated against. Additionally, the BBA included a provision allowing for CMS to further delay the incorporation of cost meas-

urement in MIPS. Congress originally intended for cost to be a component of MIPS scores by 2021. CMS has already delayed incorporating cost in MIPS scores in 2019 and 2020 to provide clinicians with additional time to prepare. Further, for the 2018 performance year, CMS made the decision to exempt an additional 585,560 clinicians from the program, exempting an unprecedented number of clinicians from the performance requirement s altogether.

NAACOS fears that continuing to dilute performance requirements and exempting nearly half of providers will discourage those clinicians who have already made a commitment to value-based care and invested time and resources towards making the shift to value-based care. Instead, Congress and CMS should reward high-performing clinicians who have invested heavily in performance improvement and should therefore be rewarded for this investment, time, and effort. While we support providing a phased-in approach to value-based payments for Medicare, it should be noted that the Agency's legacy programs, from which the MIPS program was developed, have been in existence for years and therefore these clinicians have had ample time to prepare for these changes. It is critical that Congress and CMS continue their commitment to transition providers toward value-based payments to improve the experience of care and the health of populations and reduce per capita costs of health care.

Medicare Shared Savings Program Recommendations

7. Increase MSSP BASIC Track Shared Savings Rates

Current rates shared savings rates finalized under the Pathways rules are: Basic Levels A and B: 40%; Levels C, D and E: 50%. We urge Congress to focus its efforts on not only making models with downside financial risk more attractive, but also continuing to support shared savings-only models. It is essential that Congress structure the program such that it includes a business model attractive enough to retain current participants while bringing in new ACOs to create a pipeline for ACOs to advance on the path to value-based care.

We urge Congress to provide sufficient shared savings rates to MSSP ACOs to ensure an adequate return on investment and their continued participation in the program. Specifically, increase the shared savings rates to at least the following: Basic Levels A and B: 50%; Levels C and D: 55%; Level E: 60%.

8. Eliminate the MSSP High-Low Revenue Distinction

Under the Pathways to Success Final Rule, CMS created a new distinction between "high revenue" and "low revenue" ACOs. This distinction determines program specifics, including the timing for when an ACO must move to downside risk. Low revenue ACOs are allowed additional time under lower-risk options within the Basic track, while ACOs identified as high revenue are required to transition to the Enhanced track more quickly.

We urge Congress to eliminate this distinction for the following reasons. First, the distinctions are arbitrary—being "high" or "low" revenue does not determine when an ACO is ready to take on risk or how much risk they are able to assume. As previously described, significant investments are needed in population health platforms and care process changes for ACOs to bear risk. The financial position and backing of a particular ACO, as well as the ability to assume risk depends on a variety of factors, including local market dynamics, culture, leadership, financial status, previous program success, and the resources required to address social determinants of health that influence care and outcomes for patients.

Second, the high and low revenue distinctions create unnecessary program complexity. Furthermore, the move creates uncertainty for ACOs who may have a difficult time predicting the category in which they would fall. This distinction may also change over time as ACO participant composition changes, adding more complexity and making long-term planning very difficult. Removing the distinction would minimize some of the complexity and uncertainty.

9. Provide More Time in Shared Savings-only Models and Keep the Enhanced Track Voluntary

Currently, CMS only allows ACOs entering the program on the Basic Track to be in a one-sided risk contract for two to three years. ACOs previously in the program can only be in a one-sided risk model for one year. CMS also expects Basic Track ACOs to eventually transition to the Enhanced Track and therefore take on the most downside risk.

While there should be movement towards risk, ACOs need more time to produce positive financial results and such a movement should be appropriate and reasonable to encourage participation in the MSSP which is a voluntary program. The levels of risk required in two-sided models such as the Enhanced Track are much higher than what many ACOs can bear and are not viable options for most ACOs. The decision to take on risk is critical to an ACO's choice about which model to select and having to potentially pay millions of dollars to Medicare is not feasible for many of these organizations. Requiring ACOs to assume downside risk may result in many ACOs dropping out of the MSSP, which is an unintended consequence and will immediately reduce incentives to help bend the cost curve in Medicare.

We urge Congress to allow MSSP ACOs to remain in a shared savings-only model for at least three years before being required to assume any risk and to not require any ACOs to participate in the Enhanced track. This increased timeline and enhanced flexibility related to risk will help ACOs better prepare to take on downside risk, increase participation, and lead to more successful outcomes.

10. Update the MSSP Risk Adjustment Methodology

CMS uses the CMS Hierarchical Condition Category (CMS–HCC) prospective risk adjustment models to calculate beneficiary risk scores, adjust the benchmark years used for the historical benchmark, and compute the rebased historical benchmark. Accurate risk adjustment is imperative to assess ACO performance, as risk adjustment should remove or minimize differences in health and other risk factors that impact performance but are outside the ACO's control. The risk adjustment cap finalized in the Pathways to Success rule allows up to a 3 percent increase over five years and should be increased. A risk adjustment methodology that allows risk adjustment scores to increase even more will give ACOs a better ability to meet their financial benchmarks. A downward cap should also be used, thus controlling for outliers on both ends of the spectrum. Further, Congress should require CMS to provide additional transparency on the risk adjustment methodology, which would allow ACOs to better understand the process and provide more certainty.

Specifically, Congress should:

i. Implement a risk adjustment methodology that allows risk adjustment scores to increase at least 5% over 5-year agreement period and apply a cap of up to −5% on downward adjustments.

ii. Require CMS to provide full transparency on the methodology (ex. algorithms) used in risk adjustment.

iii. Provide funding for an independent study comparing Medicare risk adjustment approaches across Medicare programs (including APMs and Medicare Advantage).

11. Modify the MSSP Benchmarking Methodology

There remain a number of flaws with the MSSP benchmarking methodology which must be addressed. Benchmarking is of the utmost importance to ACOs; it is a fundamental program methodology which determines how ACOs perform individually and is one of the ways CMS evaluates the overall success of the program.

Under the regional benchmarking methodology, CMS uses all "assignable beneficiaries," including ACO assigned beneficiaries, in determining expenditures for the ACO's region. The determination of which beneficiaries are included in the regional population is very important as this population is the basis for calculating the regional expenditure data that is factored into benchmarks that include a regional component. Rather than comparing ACOs to themselves and other ACOs, CMS should compare ACO performance relative to fee for service (FFS) Medicare by defining the regional reference population as assignable beneficiaries without ACO-assigned beneficiaries for all ACOs in the region. At the very least, Congress should exclude the ACO itself from the region to prevent an otherwise tautological comparison that essentially double counts those ACO-assigned beneficiaries.

12. Allow NPI-level Participation in the MSSP

Currently, MSSP ACO participation is limited to participation at the Tax Identification Number (TIN) level (*i.e.,* acute care hospitals, group practice, solo practice, long term care hospitals, skilled nursing facilities, etc.). Participants in MSSP ACOs are identified by their TIN number. Consequently, there is no option for MSSP ACO participation at the National Provider Identifier (NPI) level.

This limitation presents challenges for individuals who wish to participate in an ACO and practice in a group setting that does not participate in an ACO under its

TIN. Because providers cannot participate at the TIN level as an individual unless engaged in solo practice, they cannot participate in the program. We recommend Congress allows NPI-level participation in the MSSP to increase opportunities for participation and provide greater flexibility across a wider range of providers.

13. Provide Upfront Payments to Help ACOs Get Started and Assist Providers That Have Difficulty Moving to Risk

Congress recognized the principle from the ACO authorizing statute that one of the purposes of creating ACOs is to "encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery." ACOs require a significant amount of investment to develop the necessary infrastructure and effectively adjust to a different approach to care. These investments are for clinical and care management, health IT/population analytics/reporting, and ACO management and administration. Not only do such investments require a significant amount of time and money, but they also require organizations to incur a substantial amount of risk apart from any risk associated with strictly providing care. The cost of the necessary infrastructure and operating expenses may deter ACOs from starting up in the first place or continuing on the path to value, as there is no guarantee that the ACOs will earn back the expenses associated with such investments.

We urge Congress to provide greater support to ACOs by providing upfront and ongoing payments to assist with such investments and operating costs. CMS previously offered programs to help fund ACOs up front, with those payments later recouped via shared savings. These programs, such as the ACO Investment Model (AIM), should be reinstated to help ACOs fund activities and transformations early on in ACOs' development.

14. Increase the MSSP BASIC Track Shared Savings Rates Based on Quality Performance

Currently, an ACO that achieves CMS's established quality performance levels is not rewarded and is instead merely prevented from forfeiting the shared savings payments it has earned. There is no direct financial reward for improving quality of care and no penalty for poor quality unless the ACO has generated savings. This lack of reward can be a strong disincentive for ACOs to invest in quality improvement. Many efforts to improve the quality of care consume ACO resources and increase spending relative to the ACO's financial benchmark in the short term, even if they decrease Medicare spending over the long term. The more an ACO strives to improve quality performance, the more it often needs to spend. If the services used to improve quality are billable services, they will increase the ACO's spending and reduce the probability of beating its benchmark.

To emphasize and reward above average quality performance or improvement, we urge Congress to provide on a sliding scale up to 10 percentage points of additional shared savings to ACOs scoring in the top half of total ACO quality performance or quality improvement. Additionally, we urge Congress to add a bonus opportunity for ACOs whose quality performance is exceptional, but did not meet criteria for shared savings. Adding this bonus opportunity will more appropriately incentivize quality improvement.

Conclusion

In closing, we appreciate the committee's attention to the important issue of monitoring implementation of MACRA. We hope you will consider these comments as you continue in your efforts to ensure a successful implementation of this critical law which has the power to truly transform Medicare payments to pay for value over volume of services provided to beneficiaries.

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The Premier healthcare alliance appreciates the opportunity—to submit a statement for the record on the Senate Judiciary Committee's hearing titled "Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead" scheduled for May 8, 2019. We applaud the leadership of Chairman Grassley, Ranking Member Wyden and members of the Committee for holding this hearing to examine the Medicare Access and CHIP Reauthorization Act (MACRA)

of 2015 and assess how well that reform legislation is meeting its goals of improving quality of care and value for taxpayers.

Premier strongly supports the intent of MACRA's Quality Payment Program (QPP) to help fix the misaligned incentives in our traditional fee-for-service Medicare program. Premier is an ardent supporter of the transition toward models where providers are accountable and rewarded for high-quality, cost-effective care.

Physician Incentives: Extending the AAPM Bonus

MACRA is designed to encourage clinicians to participate in alternative payment models (APMs) as a way to move from a volume-based healthcare system to a value-based system where healthcare providers organize to collaborate to deliver better outcomes. The Advanced APM (AAPM) bonus that was established by MACRA to accelerate this movement to value-based care expires in 2024 (payment year 2022). This means that new accountable care organizations (ACOs) entering the Medicare Shared Savings Program (MSSP) Pathways to Success in July 2019 or January 2020 do not have an opportunity to receive the AAPM bonus. MACRA was written with the assumption of the availability of additional AAPMs that would be eligible for the 5 percent bonus in OPP. While Premier is encouraged by the recent new models announced by the Center for Medicare and Medicaid Innovation, the rollout of new APMs, particularly models in which specialists can participate, has been slow.

To allow MACRA to work as intended, *Premier urges Congress to extend the AAPM bonus at least six additional years,* through payment year 2030 (performance year 2028).

Giving CMS Authority to Adjust the QP Thresholds

Under MACRA; eligible professionals (EP) who meet certain revenue thresholds for participation in an APM are considered qualified participants. (QP) or partial qualified participants. QPs receive 5 percent bonus payment on their services billed under the physician fee schedule and are exempt from MIPS; partial QPs do not receive a bonus but are exempt from MIPS unless they participate in MIPS. The thresholds to qualify for the AAPM bonus (QP thresholds) are set in statute for the *payment* threshold, but CMS has the authority to set the *patient* threshold. The thresholds increase every other year. Due to the lack of availability of AAPMs and the structure of these models, it will be increasingly difficult to meet the QP threshold. In the patient count method, CMS has adjusted the thresholds in response to MPM penetration and the type of models available. *We urge Congress to also grant CMS the authority to adjust the payment thresholds.*

In closing, the Premier healthcare alliance appreciates the opportunity to submit a statement for the record on the Senate Finance Committee hearing on MACRA. As an established leader in pay for performance, bundled payment and accountable care organization (ACO) models, Premier is available as a resource and looks forward to working with Congress as it considers policy options to address this very important issue.

If you have any questions regarding our comments or need more information, please contact Aisha Pittman, Senior Director of, at aishapittman@premierinc.com or 202–879–8013.

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Dear Chairman Grassley, Ranking Member Wyden, and Members of the Committee, the Society of Hospital Medicine (SHM), on behalf of the nation's hospitalists, is pleased to offer our comments to the Senate Finance Committee regarding the recent hearing entitled, "Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead."

Hospitalists are front-line clinicians in America's acute care hospitals whose professional focus is the general medical care of hospitalized patients. Their unique position in the healthcare system affords hospitalists a distinct perspective and systems-based approach to confronting and solving challenges at the individual provider- and overall institutional-level of the hospital. In this capacity, hospitalists not only manage the inpatient clinical care of their patients, but also work to enhance the performance of their hospitals and health systems. They provide care for millions of pa-

tients each year, including a large majority of hospitalized Medicare beneficiaries, and are national leaders in quality improvement, resource stewardship and care coordination.

Since the inception of the specialty of hospital medicine and the founding of SHM in the 1990s, hospitalists have been at the forefront of delivery and payment system reform. They are integral leaders in helping the healthcare system move from volume to value. Hospitalists from across the country are engaged in driving innovation aimed at achieving higher quality and lower cost care for their patients. As such, they are key leaders and partners in alternative payment model (APM) adoption, including bundled payments, the Medicare Shared Savings Program Accountable Care Organizations (ACOs), and managed care.

The Medicare Access and CHIP Reauthorization Act (MACRA) created two pathways to encourage providers to move away from Medicare fee-for-service (FFS) billing: Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS). MACRA seeks to incentivize providers to utilize payment structures that focus on value, rather than volume, of care. We are very supportive of Congress' efforts to reform the FFS payment system and believe more must be done to drive innovation and align incentives for lower-cost, high quality care. Through our members' experiences in the first few years of the program, we have identified several concerns and provide suggestions below.

Barriers to Alternative Payment Model (APM) Adoption

MACRA seeks to incentivize providers to move away from fee-for-service (FFS) Medicare towards APMs. Qualified participation in an APM provides an exemption from the MIPS and a 5 percent lump sum incentive payment through 2024. In order to determine whether a provider qualifies for the APM pathway of MACRA, the law established thresholds of payment or patients. In 2019 and 2020, the thresholds are set at 25 percent of Medicare payments; 2021 and 2022 at 50 percent; 2023 and beyond at 75 percent. For patient count, providers must meet generally similar thresholds in each year. Starting in 2021, the thresholds may be met through an all-payer analysis, though providers must still reach a minimum threshold of Medicare payments or patients. We understand the law specified these thresholds to ensure that providers are meaningfully engaged with the APM and have moved significantly away from FFS Medicare.

SHM believes that encouraging providers to move into APMs is the most important aspect of MACRA. We see APMs as the only pathway away from the costly FFS system. APMs are also important because they return a significant amount of control directly to providers. That said, the threshold model of APM participation creates a major barrier for many providers, leaving them stuck in traditional fee-for-service Medicare and the MIPS. Small fluctuations in patient mix can result in providers qualifying as APM participants one year and not the next. In addition, some of the APM models, such as Bundled Payments for Care Improvement (BPCI) Advanced, are condition-based, meaning generalists like hospitalists will be unable to collect enough payments or patients to meet the threshold. In the original BPCI, hospitalist participants that engaged with 12 different condition bundles in the model were unable to meet even the lowest thresholds set for the program.

We believe the thresholds serve as an impediment to meeting the intent of MACRA and, importantly, as a barrier to cost containment. Well-designed APMs have the potential to save a significant amount of money for the Medicare Trust Fund, while the budget-neutral MIPS does not share the same potential. To save money, we must move more providers off of fee-for-service and onto APMs.

Rethinking Exclusions Under the MIPS

The Merit-based Incentive Payment System (MIPS) was developed to transition the traditional Medicare fee-for-service payment system into value-based payments. We have serious concerns about the effectiveness of the program, as nearly 60 percent of providers are completely exempt from the program under current Medicare policies. Since the MIPS is a budget-neutral program, the money used to incentivize high performers is taken from underperforming providers who are penalized. As more providers are exempted from the program, the pool of potential payments for high performing providers has decreased significantly. To ensure compliance in the MIPS, providers that are not exempt have had to invest significantly in data infrastructure, administration and reporting under the program. However, with such large numbers of exempt providers, the potential return on those investments are negligible. With so many providers exempt from the program, we also have serious

concerns about the relevance and accuracy of data reflected by measures that are being reported in the MIPS.

CMS has indicated through rulemaking that they believe exemptions from the program are necessary because of concerns about the validity of data in measures with small case volumes and the financial burdens placed on providers for reporting. We believe these exemptions and the reasoning for them are evidence of serious structural flaws within the program. Policymakers should focus on refinements aimed at achieving a meaningful program that yields simple and actionable feedback for all Medicare providers.

Pay for Performance: Are We Measuring the Right Things?

Measurement has become a central feature of the Medicare system. The use of measurement in pay-for-performance programs is built around an assumption that measurement can lead to improvements in quality and reductions in cost. SHM agrees that well-designed measures have the potential to yield these outcomes and may be worth the time, work, and cost to implement. Looking at the MIPS, current policies create a complicated program with measures that give providers very little meaningful and actionable feedback. Providers spend a significant amount of time and money on reporting quality measures that may not be reflective of their entire practice or even report on most of their Medicare patients. Instead, they are participating in the MIPS as a compliance effort to avoid significant penalties.

We believe there is an ample opportunity to step back from siloed and micromanaged quality and cost measures and focus on developing indicators for the quality and safety of healthcare and on the general health and well-being of communities. Shared accountability between providers on these broad indicators will lead to the proliferation of local-level quality improvement and cost-reduction efforts. This systems-based approach, while it does not contain the most narrowly tailored measures to specific specialties or individual clinicians, is how patients view the healthcare system and is ultimately how providers must work together to improve quality and decrease costs. We believe the goal of the MIPS should be to point providers in the right direction by aligning incentives and having simple and clear markers that are shared across providers and specialties.

Policy and Definitions That Are Inconsistent With Practice Realities

Often, MIPS/MACRA definitions and policy does not align with practice realities. A clear example of this is an issue that facility-based providers, including hospitalists, are facing with the definition of hospital based group in the Promoting Interoperability (formerly Advancing Care Information) category of the Merit-based Incentive Payment System (MIPS).

Hospital-based providers are meant to be exempt from the Promoting Interoperability (PI) category in the MIPS. This policy acknowledges that these providers are working in settings that use Certified Electronic Health Record Technology (CEHRT) and participate as providers working in eligible hospitals in the Promoting Interoperability Program (formerly EHR Incentive Program). It prevents unnecessary duplication and excessive administrative burden practices that work primarily in the hospital. We note the policy is meant to account for how hospital-based providers are already doing work for their hospitals to meet similar or identical requirements in the eligible hospital Promoting Interoperability Program. Furthermore, it protects hospital-based providers from being penalized for factors outside of their control, since they do not always have full access to or influence over the CEHRT used in their facilities.

To determine whether a MIPS eligible clinician (defined as a unique Taxpayer Identification Number National Provider Identifier (TIN–NPI) combination) is exempt from PI as a hospital-based provider, the Centers for Medicare and Medicaid Services (CMS) uses a threshold of 75 percent of covered professional services in Place of Service (POS) codes for off-campus outpatient hospital (POS 19), inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or emergency room (POS 23) during a 12-month determination period. If a MIPS eligible clinician meets or exceeds this threshold, they are exempt from the PI category and the category weighting is reallocated to the MIPS Quality category.

To determine whether a group is exempt as a hospital-based group, CMS has indicated that 100 percent of the eligible clinicians associated with the group must be designated as hospital-based during the same 12-month determination period. This extremely restrictive definition is inconsistent with the overarching intent of the hospital-based PI exemption as it requires groups that have only a single provider whose billing deviates from the exemption to participate in PI. This does not only

make sense in the real world of medical practice but is also resulting in many hospital-based providers being subject to unfair penalties that are not of their making and have nothing to do with their performance.

It is imperative that the MIPS policies and definitions reflect practice realities in order to make the program as relevant as possible to providers. We encourage the Committee to work with CMS and with stakeholders to identify areas where policy changes must be made to ensure practices are accurately represented and assessed under pay for performance programs.

Conclusion

The Society of Hospital Medicine looks forward to working with the Committee as it looks to achieve the shared goals of MACRA: higher quality care at lower cost. We stand ready to help craft policies that are not only easier for providers to understand, but also aim toward better accomplishing the stated intent of MACRA.

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May 21, 2019

The Honorable Chuck Grassley
Chairman
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
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Dear Senators Grassley and Wyden,

On behalf of The Society of Thoracic Surgeons, I write to thank you for hosting the May 8, 2019 hearing titled, "Medicare Physician Payment Reform After Two Years: Examining MACRA Implementation and the Road Ahead." We appreciate your continued oversight on the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA).

Founded in 1964, STS is an international not-for-profit organization representing more than 7,000 cardiothoracic surgeons, researchers, and allied health care professionals in 90 countries who are dedicated to ensuring the best surgical care for patients with diseases of the heart, lungs, and other organs in the chest. The mission of the Society is to enhance the ability of cardiothoracic surgeons to provide the highest quality patient care through education, research, and advocacy.

Merit-based Incentive Payment System (MIPS)

MACRA was designed to promote value (quality/cost) rather than simply rewarding physicians for the volume of service they provide. This means the Centers for Medicare and Medicaid Services (CMS) must be able to effectively measure quality. STS has been a pioneer in this space with the STS National Database (the Database) that recently received the John M. Eisenberg Patient Safety and Quality award from the National Quality Forum (NQF) and The Joint Commission. The Database, established in 1989, includes subspecialty registries for adult and pediatric cardiac surgery, mechanical circulatory support, and general thoracic surgery. Using data from the registry, STS has developed risk models and NQF-endorsed composite performance measures for all of its subspecialties and major procedures to help providers guide their improvement initiatives. These measures are the basis for the Society's highly successful voluntary public reporting program.

Unfortunately, none of this expertise is being utilized in the Merit-Based Incentive Payment System (MIPS). As practices continue to consolidate, an increasing number of surgeons work under larger, multi-specialty and often facility-based groups. Since these groups often opt to participate in federal quality reporting programs at the hospital or group practice level (*i.e.,* at the Taxpayer Identification Number level), the individual clinicians in these practices are increasingly losing autonomy over the selection of measures and reporting mechanisms that are most relevant to their specific specialty and patient population. This arrangement means that cardiothoracic surgeons are not able to influence their own personal quality scores as their hospitals or groups may elect to report on quality measures that are insignificant or

irrelevant to cardiothoracic surgery. This will result in a number of problems for physicians, patients, and the Medicare program:

a. MACRA was founded on the principles of promoting and incentivizing quality care throughout health care. However, without utilizing cardiothoracic surgery specific quality measures, CMS fails to incentivize quality in one of the specialties that has the largest impact on Medicare beneficiaries and is one of the largest cost centers in the Medicare program.

b. Without utilizing measures specific to cardiothoracic surgery, cardiothoracic surgeons are not able to quantify their value to their employers and may have their contribution to the overall performance of the hospital diminished.

STS has urged CMS to ensure that specialists, including physicians employed by hospitals or group practices, have the option to report on quality metrics that are germane to their practice. CMS has adopted a policy whereby physicians can report via multiple mechanisms and have their MIPS scores calculated based on the highest reported score. This policy fails to give adequate incentive for physicians to report on the quality measures that are most relevant to them. Until CMS levels the playing field and recognizes the value of true quality measurement, the MIPS program will fail to realize its purpose of incentivizing high value care.

Alternative Payment Models (APMs)

Medicare Claims Data

The Quality Payment Program (QPP) that was derived from the MACRA statute was intended to create value in health care. Indeed, the most valuable tool for patients who are interested in making proactive choices about their health care is value transparency. Fortunately, the Database already provides for quality transparency through STS Public Reporting online. If CMS were to adequately implement Section 105(b) of MACRA (Pub. L. 114–10), we would have access to Medicare claims data, or the cost denominator of the value equation. These datasets would also help us to develop and adequately benchmark novel APM concepts and advance the value proposition throughout the Medicare program. Unfortunately, the programs CMS has offered to implement that section of statute are not working.

Section 105(b) of MACRA requires CMS to provide Qualified Clinical Data Registries (QCDRs) with access to Medicare data for purposes of linking such data with clinical outcomes data and performing risk-adjusted, scientifically valid analyses and research to support quality improvement or patient safety. CMS initially decided not to issue rulemaking on this section of the law based on its assertion that QCDRs currently can request Medicare claims data through the Research Data Assistance Center (ResDAC) data request process. This position ignored the fact that Section 105(b) is intended to provide QCDRs with access to Medicare data for quality improvement purposes, not just clinical research, and that the broad and continuous access needed for quality improvement purposes is fundamentally different than the access to Medicare data for research purposes provided by ResDAC. In subsequent rulemaking, CMS decided to treat QCDRs as "quasi-qualified entities" for purposes of obtaining access to Medicare claims data for quality improvement, but maintained that QCDRs should use the ResDAC application process for research.

While we appreciate that CMS has made some effort to provide QCDRs with an alternative means of accessing Medicare data, treating QCDRs as quasi-qualified entities does not allow the type of access contemplated by Section 105(b) of MACRA. To perform data analysis for quality improvement purposes and patient safety, QCDRs require long-term and continuous access to large Medicare datasets so that they can better track clinical outcomes longitudinally. In drafting Section 105(b) of MACRA, Congress was aware of this need and, as such, specifically directed CMS to provide QCDRs with Medicare claims data. Qualified entity status lasts for only three years and continued participation in the program requires re-application by submitting documentation of any changes to the original application. If the re-application is denied, CMS will terminate its relationship with the qualified entity. In addition, Medicare fee-for-service files are released quarterly on an approximate 5.5 month lag. Qualified entities must pay for each set of data they receive, which can become cost prohibitive over time.

Further, the quasi-qualified entity program covers only the "quality improvement" portion of a QCDR's access to claims data. If the same QCDR wanted to facilitate research combining cost and claims information, that QCDR would have to submit a separate application to ResDAC. In fact, if the QCDR already had the claims data in question through the quasi-qualified entity program, it would still need to apply and pay ResDAC for the same data. The ResDAC application is duplicative, time-

consuming, and costly, with a significant lag between application approval and delivery of data.

At the same time, every new payment model released by CMS and the Center for Medicare and Medicaid Innovation (the Innovation Center) includes a provision that hospitals and qualified participants should be able to access their own claims information and any additional information deemed necessary by the participant. Clearly, CMS understands the value of price transparency in health care, yet it is failing to implement statute that speaks to that purpose. If CMS is truly interested in using its existing authority to provide information on the value of health care to the Medicare population, it will take another look at how it is implementing Section 105(b) of MACRA. Absent that ideal scenario, CMS should provide claims data to the providers with a straightforward breakdown of inpatient costs, provider costs, post-acute care costs, home health costs, readmission rates, and costs. Given these data and local or regional (not necessarily national) benchmarks, providers (and patients) will have an idea where care can improve and where there are opportunities to improve efficiency. If benchmark prices from big data are created, the methodology employed should be clear and include relevant stakeholders in the development.

Physician-focused Payment Model Technical Advisory Committee (PTAC)

MACRA was founded on the principles of incentivizing value over volume. As such, considerable emphasis was placed within MACRA on development of and participation in alternative payment models (APMs). Specifically, Congress created the physician-focused payment model technical advisory committee (PTAC) to both improve transparency at the Innovation Center and increase the variety, efficacy and number of APMs, in hopes of maximizing the number of physicians and medical specialties able to participate. STS was prepared to offer a physician focused payment model (PFPM) to both the PTAC and the Innovation Center for consideration and implementation. Because of our unique resource—the Database—we believed that we would be able to demonstrate to CMS a payment model capable of rewarding physicians for increasing the quality of care they provide and reducing resource use. Unfortunately, the APM pathway has become extremely complicated and difficult to navigate. According to legal review by the office of the Assistant Secretary for Planning and Evaluation, under current statute, PTAC is not able to provide technical assistance to stakeholders during APM development. Without this assistance, APMs eventually fail to navigate the complexities of getting a proposed APM from development through PTAC review and on to Innovation Center implementation. Although Congress attempted to address this concern with language added to the Balanced Budget Act of 2018, PTAC has indicated that it is still not able to provide technical assistance and data analyses to stakeholders who are developing proposals for its review. Additional technical corrections may be needed to provide the PTAC with more flexibility in this regard.

Bundled Payment for Care Improvement—Advanced (BPCI–A)

A notable success of MACRA implementation has been our recent collaboration with the Innovation Center on the development of quality measures for two episodes of care contained in BPCI–A. Unlike our experience with other APMs, staff from the Innovation Center proactively sought, and utilized feedback from stakeholders on how to adequately measure quality within a payment bundle. The result is that the Innovation Center is looking to implement episodes under BPCI–A that rely on clinical data registries for true quality reporting.

The failed mandatory Coronary Artery Bypass Graft (CABG) episode payment model (EPM) provides a perfect example of why this is so important. Under the proposed CABG EPM, CMS intended to use two quality measures: a patient assessment of care and all-cause mortality. It is understandable that CMS would identify these measures because they are easy to quantify with the tools they have available. However, they do not paint an adequate picture of quality. The mortality rate for CABG is already at 2%. We questioned how CMS planned to distinguish among EPM participants if 98% of them were already hitting the prescribed quality benchmark.

The proposed CABG episode under BPCI–A intends to offer a far more robust quality measure: the STS-developed CABG Composite Score. The STS CABG Composite Score is calculated using a combination of 11 measures of quality divided into four broad categories or domains. Importantly, the 11 individual measures and the overall composite measure methodology are all endorsed by the NQF and have undergone careful scrutiny by quality measure experts. The four domains are:

- Risk-adjusted mortality.
- Risk-adjusted major morbidity, which represents the percentage of patients who leave the hospital with none of the five most serious complications (often referred to as morbidities) of CABG-reoperation, stroke, kidney failure, infection of the chest wound, or prolonged need to be supported by a breathing machine, or ventilator. Some of these complications, such as stroke or kidney failure, are just as important to many patients as whether they survive the surgery, as these outcomes profoundly impact quality of life. Overall, based on data from the Database, about 85 percent of patients are discharged with no such complications.
- The percentage of CABG procedures that include the use of at least one of the arteries from the underside of the chest wall—the internal mammary (or internal thoracic) artery—for bypass grafting. This artery has been shown to function much longer than vein grafts, which can become blocked over time.
- How often all of the four medications believed to improve a patient's immediate and long-term outcomes were prescribed. These medications include beta-blocking drugs prescribed pre-operatively, as well as aspirin (or similar drugs to prevent graft clotting), and additional beta-blockers and cholesterol-lowering medicines prescribed at discharge.

Without registries, CMS did not have a way to effectively measure quality for CABG, one of the most common procedures performed in the Medicare population and therefore one of the major Medicare cost centers. By working together, we have been able to design an episode that should be able to more effectively demonstrate value.

Other

Electronic Health Records (EHR)

Data-blocking by electronic health records (EHR) vendors remains a significant barrier to the provision of high quality health care. Additional provisions included in the 21st Century Cures Act address lack of interoperability among EHRs but also between EHRs and clinical data registries. The recent proposed rules on interoperability did not provide great detail on how these data-sharing concerns will be addressed. We urge Congress to continue to carefully monitor this implementation, with special interest in how the practice of data-blocking is inhibiting success under the QPP.

MIPS Payment Adjustments and APM Glide Path

We agree with many of the panelists who testified about their concerns that Medicare payments have failed to keep up with inflation. We are also concerned that, due to the way MACRA has been implemented, many physicians have not had an APM available to them so they could not benefit from the statutory bonus Congress created to facilitate physicians' transition to APMs. We agree that Congress should intervene to replace the upcoming physician payment freeze with positive payment updates under MIPS and extend the APM bonus so more physicians have the opportunity to transition to APMs.

We strongly disagree with the testimony that CMS should use a budget-neutral approach that would increase payment rates for ambulatory E/M services while reducing payment rates for other services (*e.g.,* procedures, imaging, and tests). We support the proposed E/M payment rate changes as proposed by the RVS Update Committee (RUC). As with any other rate changes, budget neutrality adjustments are required. We strongly urge the Senate Finance Committee to apply any budget neutrality adjustments across all specialties. Recent policy has continually favored primary care over other specialists (*e.g.,* surgery, imaging and testing) to the detriment of these specialists. Our specialty society worked with primary care and others to help correct payment changes related to the work of all physicians. To favor primary care over other specialties in this circumstance would impact the integrity of the process. While we support primary care physicians and initiatives supporting them and their work, we do not support it at the expense of other specialists.

STS remains fully committed to improving the quality, safety, and efficiency of care for all patients. We had hoped that MACRA would help to move our healthcare system toward a value based system. However, we remain frustrated with the implementation of MACRA. We hope that Congress and CMS can work together to truly measure quality and allow for more alternative payment models that reimagine how health care is delivered. We look forward to working with you on this issue. Please contact Courtney Yohe Savage, STS Director of Government Relations, at

cyohe@sts.org or 202–787–1230 should you need additional information or clarification.

Sincerely,

Robert S.D. Higgins, MD
President

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