

**MEDICARE ACCESS AND CHIP REAUTHORIZATION
ACT OF 2015: EXAMINING IMPLEMENTATION
OF MEDICARE PAYMENT REFORMS**

HEARING
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SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
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CONTENTS

	Page
Hon. Joseph R. Pitts, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement	1
Prepared statement	2
Hon. Gene Green, a Representative in Congress from the State of Texas, opening statement	3
Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, opening statement	5
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	6
Prepared statement	7

WITNESSES

Patrick Conway, MD, Acting Principal Deputy Administrator, Deputy Administrator for Innovation and Quality, and Chief Medical Officer, Centers for Medicare & Medicaid Services	9
Prepared statement	12
Answers to submitted questions	69

SUBMITTED MATERIAL

Statement of the American Hospital Association, submitted by Mr. Pitts	44
Statement of the American Academy of Dermatology Association, submitted by Mr. Pitts	50
Statement of the American Society of Clinical Oncology, submitted by Mr. Pitts	54
Statement of the College of Healthcare Information Management Executives, submitted by Mr. Pitts	62
Statement of the Healthcare Leadership Council ¹	65

¹ The attachments to this document can be found at: <http://docs.house.gov/meetings/if/if14/20160317/104683/hhrg-114-if14-20160317-sd008.pdf>.

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015: EXAMINING IMPLEMENTATION OF MEDICARE PAYMENT REFORMS

THURSDAY, MARCH 17, 2016

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

The subcommittee met, pursuant to call, at 10:00 a.m., in room 2322 Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Guthrie, Shimkus, Murphy, Burgess, Blackburn, Lance, Griffith, Bilirakis, Ellmers, Bucshon, Brooks, Collins, Green, Capps, Schakowsky, Butterfield, Castor, Sarbanes, Matsui, Kennedy, and Pallone (ex officio).

Staff present: Rebecca Card, Assistant Press Secretary; James Paluskiewicz, Professional Staff Member; Graham Pittman, Legislative Clerk; Adrianna Simonelli, Legislative Associate, Health; Heidi Stirrup, Health Policy Coordinator; Christine Brennan, Minority Press Secretary; Jeff Carroll, Minority Staff Director; Kyle Fischer, Minority Health Fellow; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and Arielle Woronoff, Minority Health Counsel.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order. The chair recognizes himself for an opening statement.

Today's hearing will provide an opportunity for the Health Subcommittee to review the implementation and progress of the Medicare payment reforms as included in the historic legislation which repealed the Sustainable Growth Rate, the SGR, and replaced it with new payment models and other reforms.

And I say historic, because my colleagues know well we worked over many years to address problems associated with the SGR and impending yearly payment cuts to doctors that inevitably were avoided thanks to short term, temporary patches, 17 in all.

Many were interested in finding a solution, but not until the Medicare Access and CHIP Reauthorization Act 2015, MACRA, was enacted with overwhelming bipartisan support in the House and

Senate did we finally achieve reforms for physician payments while also promoting high quality care for patients.

Through a variety of incentives, physicians are encouraged to engage in activities to improve quality. Existing quality reporting programs are consolidated and streamlined into a new Merit-based Incentive Payment System, MIPS. Strong incentives are created for physicians to participate in the qualified Alternative Payment Models, APM, and I would like to speak to one such APM, patient-centered medical homes, which are an innovative model of care that has been shown to improve outcomes, patient experience, and reduce costs.

Physicians in qualified medical homes will get the highest possible score for the practice improvement category in the new MIPS program. Medical homes that have demonstrated to the U.S. Department of Health and Human Services the capability to improve quality without increasing costs, or lower costs without harming quality, will not have to accept direct financial risk.

Physicians in qualified APMs will receive a five percent bonus from 2019 to 2024. Technical support is provided for smaller practices funded at \$20 million per year from 2016 to 2020 to help them participate in APMs, or the new MIPS program. Funding is also provided for quality measured development at \$15 million per year from 2015 to 2019, and physicians will retain their role in developing quality standards.

Along with these physician payment reforms, MACRA also reauthorized the National Health Service Corps, community health centers, teaching health centers and Children's Health Insurance Programs, CHIP, all of which will help to ensure patient access to primary care.

Today's hearing will be focused exclusively on the Medicare payment reforms and with our expert witness from the Centers for Medicare & Medicaid Services, CMS. Members will have an opportunity to learn about CMS' work to leverage performance measures with new payment models to build a better system that improves overall care for our seniors while also reducing costs.

I will now yield to the vice chair of the full committee, Mrs. Blackburn.

[The statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Subcommittee will come to order.

The Chairman will recognize himself for an opening statement.

Today's hearing will provide an opportunity for the Health Subcommittee to review the implementation progress of the Medicare payment reforms as included in the historic legislation which repealed the Sustained Growth Rate (SGR) and replaced it with new payment models and other reforms.

I say 'historic' because as my colleagues know well, we worked over many years to address the problems associated with the SGR and impending yearly payment cuts to doctors that inevitably were avoided thanks to short-term, temporary patches—17 in all.

Many were interested in finding a solution, but not until the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was enacted—with overwhelming bipartisan support in the House and Senate—did we finally achieve reforms for physician payments while also promoting high quality care for patients. Through a variety of incentives, physicians are encouraged to engage in activities to improve quality. Existing quality reporting programs are consolidated and streamlined into a new Merit-based Incentive Payment System (MIPS).

Strong incentives are created for physicians to participate in qualified Alternative Payment Models (APM) and I would like to speak to one such APM, Patient Centered Medical Homes (PCMHs), which are an innovative model of care that has been shown to improve outcomes, patient experience, and reduce costs. Physicians in qualified PCMHs will get the highest possible score for the practice improvement category in the new MIPS program. PCMHs that have demonstrated to the U.S. Department of Health & Human Services the capability to improve quality without increasing costs, or lower costs without harming quality, will not have to accept direct financial risk.

Physicians in qualified APMs will receive a 5 percent bonus from 2019–2024. Technical support is provided for smaller practices, funded at \$20 million per year from 2016 to 2020 to help them participate in APMs or the new MIPS program. Funding is also provided for quality measure development at \$15 million per year from 2015 to 2019 and physicians will retain their role in developing quality standards.

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I will now yield to _____.

Mrs. BLACKBURN. Thank you, Mr. Chairman. Dr. Conway, welcome. We are delighted to see you here.

And as I have been about in my district the last several days, one of the things I have heard from health care providers and heard at one of my health care town halls over in Bolivar, Tennessee, is that population health tools are useful, they want to utilize these, and in the Nashville area they want to see continued innovation in this arena.

We are kind of the Silicon Valley, if you will, of health care informatics and utilization with all the hospital management companies that are there. They have a problem and this is that meaningful use has become meaningless in many instances, because you have got a few big players in the space and in order for innovation to continue there has to be a way to address interoperability and the sharing of this and allow some of these smaller utilizers and smaller vendors into this space so that the APM model can continue.

So we look forward to visiting with you today. We thank you for being here and we will look forward to addressing these issues on behalf of our constituents. I yield back.

Mr. PITTS. The chair thanks the gentlelady. I now recognize the ranking member of the subcommittee, Mr. Green, 5 minutes for an opening statement.

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

Mr. GREEN. Thank you, Chairman, and I thank Dr. Conway for being here this morning.

As we know, the Medicare Access and CHIP Reauthorization Act, or MACRA, repealed the flawed Sustainable Growth Rate, SGR, formula to provide long term stability to Medicare Physician Fee Schedule. It was critically important that Congress institute a rea-

sonable and responsible payment policy for physicians and reward value over volume.

The SGR was a budget gimmick which caused unnecessary uncertainty for Medicare beneficiaries and doctors. Congress had to enact short term patches to prevent physician payment cuts called for by the SGR 17 times. These short term SGR patches cost taxpayers more than \$170 billion and did not contain real payment reform.

Now that the historic achievement of finally repealing or replacing SGR has been made, staunch oversight over the implementation of MACRA is critical. This will ensure that we do not make the same mistakes of the past and that a system is set up that is fair, smart, and sophisticated enough to meet the unique challenges and variabilities of providers participating in the Medicare system.

As we know, MACRA provides stable updates for 5 years and ensures no changes are made to the current payment system for 4 years. In 2018, it establishes a streamlined and improved incentive payment program that will focus a fee-for-service system on providing value and quality.

The incentive payment program referred to as the Merit-based Incentive Payment System, or MIPS—we all have these abbreviations; it is really interesting—consolidates the three existing incentive programs continuing the focus on quality, resource use and meaningful electronic health record use, but is a cohesive program that avoids redundancies.

Further, this section provides financial incentives for the professionals to participate in tests of alternative payment models, APMs. It is the intent of Congress that the specific quality metric used to be tailored to different provider specialties and each eligible professional will receive a composite quality score.

The challenge is with constructing a system that fully accounts for the variabilities in providers and the type of care they are trained to provide and patient mix as how to meaningfully evaluate quality or significance, but I believe it can be accomplished.

To do so, the Centers for Medicare & Medicaid Services, CMS, has initiated the rulemaking process. And I thank the agency for their diligent attention and hope to see continued stakeholder engagement and collaboration in a transparent and public process throughout the course of the implementation. MACRA has also provided another route to incentivize the moving away from the volume based payments by giving financial bonuses to providers who participate in alternative payment methods. APMs hold great promise, but their variability and effectiveness require sophisticated construction and implementation.

I look forward to hearing from the agency through this process about its vision of the APMs, specifically how the models will be designed so they are relevant to different specialties, different sizes of practice and in line with the state based initiatives and private insurance models.

In order to both streamline and fill in current gaps in quality measures, the Secretary is required to create and publish a quality measure development plan to be used in both MIPS and APs with the input from stakeholders by May 1st of this year. This plan

should prioritize outcome measures, patient experience measures, care coordination measures, measures of appropriate use of services, and should also consider gaps in quality measurement and applicability of measures across the health care setting.

Interoperability, or lack thereof, has plagued the health care system since the enactment of the HITECH Act. It is important to know that MIPS and thus electronic health record meaningful use, even more tied to provider payment, the importance of getting to an interoperable system has never been greater—interoperability essential to the care, coordination and integration, the heart of the move toward a system that rewards value over volume and provides cost effective quality care to beneficiaries. MIPS is still around the corner and time for action is now.

I look forward to continuing to work with my colleagues. I want to thank Chairman Upton, Ranking Member Pallone, Representative Burgess, for their partnership and leadership on the issue, and thank our chairman for calling this hearing today and Dr. Conway for being here. I look forward to hearing and continuing engagement with CMS through the process, and I yield back 32 seconds.

Mr. PITTS. The chair thanks the gentleman and now recognizes Dr. Burgess, 5 minutes, filling in for the chair of the committee.

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

Mr. BURGESS. Thank you, Chairman Pitts. And I will confess it is a little bit surreal to be here discussing the implementation of this Medicare provider payment reform. So many times we were here worrying about how we were going to keep the dire wolf away from the door yet one more time to stop a substantial double-digit cut to our doctors under the Sustainable Growth Rate formula.

Repeal of the Sustainable Growth Rate formula was one of the reasons that I ran for Congress, and coupled with that was a sincere desire to help my profession and to help the country's patients and to strengthen the state of health care in this country. When I ran for Congress and through the years that I have served here, the Sustainable Growth Rate formula was public enemy number one.

So we worked for 13 years after I got here to get the SGR repealed, and now with the passage of the Medicare Access and Chip Reauthorization Act of 2015, having crossed that major milestone I also recognize that our work is not done and this is going to require a significant amount of care and feeding as this program gets started and the implementation continues.

I just will make the commitment to you, Mr. Chairman, and to you, Dr. Conway, at the agency that this will remain my highest priority for the time that I remain in Congress. The Medicare Access and CHIP Reauthorization Act does represent a fundamental change in the health care payment system, a health care payment system that had remained static for many years.

In one of our other subcommittees in Energy and Commerce on the Commerce, Manufacturing, and Trade Subcommittee, we are focused on what is called the Disrupter Series. I would submit that this is disruptive, the MACRA is disruptive in the payment system space and it is disruptive by design. MACRA creates an unprece-

dedent amount of flexibility and it will allow federal policies to keep pace with the speed of innovation and change, which we all know is just, it is breathtaking.

To balance that flexibility there are guardrails placed on the roadside that will ensure that implementation is responsible, and mostly that it is driven by the needs of doctors and their patients and it doesn't follow a political agenda or be sidetracked by what might be characterized as bureaucratic inertia.

The Medicare Access and CHIP Reauthorization Act has been bipartisan from the start. Two numbers that we all ought to bear in mind this morning, 392 aye votes in the House and 92 aye votes in the Senate in a time of divided government that was unprecedented, and it simply, I think, reflects the strong desire of certainly members of this committee where, after all, is really what kicked this all off was the Energy and Commerce Committee, the sincere desire of this committee to see that this is done correctly. A common theme in the bill was to put doctors and their patients in the driver's seat, and certainly I am grateful for the ability for provider and patient groups to be able to enter their comments on the Web site at CMS. And I have spent, I haven't read all 463 responses, but your request for information I thought was timely and it is certainly instructive, and we encourage members to look at those responses that you have received so far.

And Dr. Conway, I do want to say that I appreciate the time you spend with this committee. I appreciate the time you spent coming to my office to talk about this implementation. I appreciate your continued commitment. There will be days obviously where tempers grow short and friction may be evident, but underlying I think we all recognize we have got a major job to do for our doctors and patients in this country, and I for one intend to see it through. It is critically important that we get it right, no less than the future depends upon it.

This subcommittee, or this committee and this subcommittee has worked very hard on the Cures Initiative. We need somebody there to deliver the cures when we get them and this is a major down payment on keeping doctors involved in delivering care for patients. And for that I am so very grateful for the committee for having worked hard on it and I am grateful for the agency to continuing to put it as a number one priority. I am looking forward to hearing about your work so far.

Mr. Chairman, I will yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Pallone, 5 minutes for opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman, and thank you, Dr. Conway, for being here and for all the important work you do at CMS.

We are here today to discuss one of the great bipartisan success stories of this committee during this Congress, the Medicare Access and CHIP Reauthorization Act of 2015, also known as MACRA.

Though it seems like just yesterday, it has already been nearly a year since MACRA passed the House with overwhelming bipartisan support.

The primary goal of MACRA was to resolve the issue of the Sustainable Growth Rate, or SGR, an issue that had haunted Congress for years. Created in '97, the SGR had tied the growth of Medicare physician payments to growth in gross domestic product. However, it wasn't long before Congress realized that the SGR was far from sustainable. In order to avoid massive payment cuts to physicians in the Medicare program, Congress had to temporarily fix the flawed SGR nearly 20 times since it was enacted, and these constant doc fixes came at a high price.

Since 2002, Congress spent more than \$170 billion on these short term fixes, but none of these short term patches did anything to fix the underlying issue. The fee-for-service system is broken, incentives were misaligned, Medicare was rewarding volume over value and quantity over quality.

And that is why I am so proud that this body was able to work together last year to finally come up with a solution that both repealed the SGR and put our health care financing system on a path toward rewarding value over volume or quality over quantity.

MACRA put in place a dual track system for providers. Providers who chose to remain in fee-for-service are able to do so. Instead of the patchwork of quality reporting systems that providers currently use, they will instead use the Merit-Based Incentive Payment System, or MIPS, and MIPS will streamline quality reporting for providers and incentivize high quality efficient care.

Providers can also choose to use alternative payment models, or APMs. APMs have proven to increase quality and lower costs. Providers who receive a significant portion of their the revenue from APMs will be eligible for a five percent bonus. And I am especially interested in the potential for telemedicine in the new system, both as a clinical practice and proven activity in MIPS and as part of alternative payment models.

While I am proud that our committee is such an integral part of the passage of this historic bipartisan bill, I know that our work isn't done here and that is why I am pleased that we are holding this hearing today to check in on the Administration's implementation of this law and assess what steps we should take to build on its success.

I now would like to yield the remainder of my time to Ms. Matsui.

[The statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Good morning. Thank you Mr. Chairman for holding this important hearing today, and thank you Dr. Conway for being here and for all the important work you do at CMS.

We're here today to discuss one of the great bipartisan success stories of this Committee during this Congress, the Medicare Access and CHIP Reauthorization Act of 2015, also known as MACRA. Though it seems like just yesterday, it's already been nearly a year since MACRA passed the House with overwhelming bipartisan support.

The primary goal of MACRA was to resolve the issue of the sustainable growth rate (SGR), an issue that had haunted Congress for years. Created in 1997, the SGR tied the growth in Medicare physician payments to growth in Gross Domestic Prod-

uct (GDP). However, it wasn't long before Congress realized that the SGR was far from sustainable. In order to avoid massive payment cuts to physicians in the Medicare program, Congress had to temporarily fix the flawed SGR nearly twenty times since it was enacted, and these constant "doc fixes" came at a high price. Since 2002, Congress spent more than \$170 billion on these short-term fixes. But none of these short-term patches did anything to fix the underlying issue—the fee-for-service system was broken. Incentives were misaligned. Medicare was rewarding volume over value. Quantity over quality.

That's why I'm so incredibly proud that this body was able to work together last year to finally come up with a solution that both repealed the SGR and put our health care financing system on a path towards rewarding value over volume. Quality over quantity.

MACRA put in place a dual track system for providers. Providers who choose to remain in fee-for-service are able to do so. Instead of the patchwork of quality reporting systems that providers currently use, they will instead use the Merit-Based Incentive Payment System or MIPS. MIPS will streamline quality reporting for providers and incentivize high-quality efficient care. Providers can also choose to use Alternative Payment Models or APMs. APMs have proven to increase quality and lower costs. Providers who receive a significant portion of their revenue from APMs will be eligible for a five percent bonus. I am especially interested in the potential for telemedicine in the new system—both as a clinical practice improvement activity in MIPS and as part of alternative payment models.

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Thank you, I look forward to today's discussion.

Ms. MATSUI. Thank you very much, Mr. Pallone, and thank you, Dr. Conway, for joining us here today. I am pleased that the committee came together last year to replace the broken SGR system with a new system that should provide CMS with new tools to continue on the path of rewarding physicians for value and quality rather than volume of services. I look forward to hearing today some of your ideas about what will work, and we look forward to working with you as we move ahead with the implementation.

I am particularly interested in ways that CMS can incorporate telemedicine into these value based systems. This is such an important opportunity to leverage existing and emerging technology to improve care and reduce costs. Telemedicine can accelerate our ability to coordinate and integrate care, facilitate population health management, and increase access to needed services.

Mr. Chairman, I would like to ask unanimous consent to introduce into the record a letter written this week to CMS from the Energy and Commerce Telehealth Working Group which highlights these points. We look forward to working with the agency to utilize innovation to achieve the goals of delivery system reform. Thank you, and I yield to anyone else the remaining time.

Mr. PITTS. Without objection, that will be in the record.

[The information was unavailable at the time of printing.]

Mr. PITTS. I also have UC requests. I would like to submit the following documents for the record: statements from the American Hospital Association, American Academy of Dermatology Association, American Society of Clinical Oncology, the College of Healthcare Information Management Executives, and the

Healthcare Leadership Council¹, without objection. Without objection, so ordered.

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

Mr. PITTS. That concludes our opening statements, and as usual the written opening statements of all members will be made part of the record.

I would like to thank Dr. Conway for coming today. He is the Deputy Administrator for Innovation and Quality and Chief Medical Officer, Centers for Medicare & Medicare Services.

Your written testimony will be made a part of the record. You will be given 5 minutes to summarize your testimony, and thank you very much for coming this morning. Dr. Conway, you are recognized for 5 minutes.

STATEMENT OF PATRICK CONWAY, MD, ACTING PRINCIPAL DEPUTY ADMINISTRATOR, DEPUTY ADMINISTRATOR FOR INNOVATION AND QUALITY, AND CHIEF MEDICAL OFFICER, CENTERS FOR MEDICARE & MEDICAID SERVICES

Dr. CONWAY. Chairman Pitts, Ranking Member Green, and members of the subcommittee, thank you for the invitation to discuss CMS' work to implement the Medicare Access and CHIP Reauthorization Act, or MACRA. We greatly appreciate your leadership in passing this important law which provides an opportunity for CMS to leverage performance measurement and new payment models as a key driver to further our shared goals to build a system that achieves better care, smarter spending and healthier people, and puts empowered and engaged consumers at the center of their care.

Today, almost 60 million Americans are covered by Medicare and 10,000 become eligible for Medicare every day. For many years, Medicare was primarily a fee-for-service payment system that paid health care providers based on the volume of services they delivered.

Earlier this month, the Administration announced that it had reached its goal of tying 30 percent of traditional Medicare payments to alternative payment models, 11-plus months ahead of schedule. An alternative payment model is a model that holds providers accountable for quality and total cost of care that they deliver to the population of patients they serve. These models provide a financial incentive to coordinate care for patients and to achieve better health outcomes.

Whereas, several years ago, Medicare essentially paid zero dollars through these alternative payment models, today 30 percent of Medicare payments are made through these models. This represents approximately \$117 billion in payments and is a major milestone in the continued effort towards improving quality and care coordination. We also reached our goal of having at least 85 percent of Medicare payments with a link to quality or value.

MACRA combines three existing quality programs: the Physician Quality Reporting System, the Physician Value-Based Payment Modifier, and the Medicare Electronic Health Record Incentive Pro-

¹The full statement can be found at: <http://docs.house.gov/meetings/if/if14/20160317/104683/hhrg-114-if14-20160317-sd008.pdf>.

gram into one aligned, new program, the Merit-Based Incentive program, or MIPS, beginning with payments in 2019.

Physicians and other clinicians will be evaluated under MIPS based upon a single composite score which will factor in performance on four weighted categories: quality, resource use, clinical practice improvement, and meaningful use of EHR technology. We are in the process of developing a scoring methodology that is meaningful, understandable and flexible. Our goal is for the program to be meaningful both to physicians and clinicians and the patients they serve and help shape our system for the better.

In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value while being adaptive to the needs of each clinician's individual practice and patient population. CMS is in the process of gathering or viewing feedback from patients, physicians, providers, payers, government, businesses, and other stakeholders regarding many of these topics.

In particular, we have been working side by side with the physician and consumer communities to address needs and concerns about the Medicare EHR Incentive Program as we transition it to MIPS. We aim to develop policies that will reward providers for the outcomes technology helps them achieve with their patients, provide flexibility to customize health technology to individual practice needs, and increase interoperability and promote innovation by encouraging the flow of data necessary to meet the needs of patients.

With a large majority of physicians and other clinicians who will be required to participate in the MIPS program, Congress did establish exceptions in certain situations including those clinicians participating in eligible alternative payment models, or APMs.

Professionals who meet certain thresholds of participation in these eligible APMs will be exempt from MIPS and receive a five percent incentive payment. While the statute establishes a high bar for these eligible APMs such as more than nominal risk, we will continuously search for opportunities to expand the range of options for participation in eligible APMs within the contours of the statute.

It is our intent to align MIPS and APM components of the new payment system allowing maximum flexibility for clinicians who are not ready or choose not to participate in an eligible APM and instead choose to participate in the MIPS program. Both MIPS and APMs are viable choices for physicians and other clinicians, and our goal is to enable that choice. MACRA will help Medicare move towards rewarding value and quality of physician service not just the quantity of such services.

As a practicing physician who has also led quality improvement efforts in health systems, I know the importance of quality measurement improvement. I have led work to improve quality and safety across the health system, such as measuring patient outcomes or rapidly implementing best practices.

We are at a critical juncture. We must demonstrate to clinicians and patients both the value of these new payment programs established by MACRA and the opportunity to save the health system of the future. The program must be meaningful, clearly focused on improved patient outcomes, contain achievable measures, engage physicians and other clinicians, and enable improvement over time.

Moving forward we will continue to pursue a patient-centered approach that leads to better care, smarter spending, and improved patient outcomes. The program must be meaningful, understandable and flexible for participating clinicians. It is our role and responsibility to help lead this change and to continue partnering with lawmakers, physicians and other providers, consumers and other stakeholders across the nation to make a transformed and improved health system a reality for all Americans. We all want the best care possible.

We look forward to working with you as we continue to implement this seminal piece of legislation which we thank you for, and Happy St. Patrick's Day. Thanks.

[The statement of Dr. Conway follows:]

STATEMENT OF

PATRICK CONWAY, MD, MSc

ACTING PRINCIPAL DEPUTY ADMINISTRATOR,

DEPUTY ADMINISTRATOR FOR INNOVATION AND QUALITY, AND

CHIEF MEDICAL OFFICER,

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015: EXAMINING
IMPLEMENTATION OF MEDICARE PAYMENT REFORMS

BEFORE THE

U.S. HOUSE COMMITTEE ON ENERGY & COMMERCE

SUBCOMMITTEE ON HEALTH

MARCH 17, 2016

U.S. House Committee on Energy & Commerce**Subcommittee on Health****“Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of Medicare Payment Reforms”****March 17, 2016**

Chairman Pitts, Ranking Member Green, and members of the Subcommittee, thank you for the invitation and the opportunity to discuss the Centers for Medicare & Medicaid Services’ (CMS’s) work to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The law provides an opportunity for CMS to leverage performance measurement and new payment models as a key driver to further the Administration’s commitment to building a better, smarter, healthier system that puts educated, empowered, and engaged consumers at the center of their care. It is our role and responsibility to help lead this change and to continue partnering with lawmakers, physicians, healthcare providers, consumers, and other stakeholders across the nation to make a transformed system a reality for all Americans.

Today, almost 60 million Americans are covered by Medicare — and 10,000 become eligible for Medicare every day. For many years, Medicare was primarily a fee-for-service payment system that paid health care providers based on the volume of services they delivered, not the value of those services. In January 2015, the Administration announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients. The Administration set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to alternative payment models (APMs) – such as Accountable Care Organizations (ACOs), advanced primary care medical homes, or bundled payment arrangements – by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. The Administration also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs. These goals for APMs and value-based payments are the first in the history of the Medicare program.

Earlier this month, the Administration announced that it has already reached its first goal ahead of schedule: an estimated 30 percent of Medicare payments are tied to APMs as of January 2016, and millions of Medicare patients are benefitting from better coordinated and improved quality of care.¹ This milestone was met when 121 new ACOs joined the Medicare program on top of new participants in models such as the Bundled Payments for Care Improvement Initiative and Comprehensive Primary Care Initiative.² We expect these gains will continue to increase over the course of the year with the start of the Comprehensive Care for Joint Replacement model and the Oncology Care Model. Ultimately, this shift towards quality and value will help patients receive, and doctors and other clinicians provide, the best care possible.

While we are pleased with Medicare's progress, successfully transforming the health care system depends upon a critical mass of partners adopting new models. It is vital to engage partners who are also committed to, and have a stake in, improving our health care system, including patients, providers, payers, government, and businesses. This is why we helped launch the Health Care Payment Learning and Action Network (LAN) in March 2015 to bring together stakeholders in the public and private sector to accelerate adoption of value-based payments and APMs. More than 4,800 patients, insurers, providers, states, consumer groups, employers, and other partners joined the LAN and over 50 organizations have made commitments to payment transformation, including health plans, provider organizations, consumer groups, and state governments. The LAN is working to identify areas of agreement around movement to APMs and is collaborating to generate evidence, share best practices, and remove barriers to success. Just one example of the LAN's work is the development of a detailed framework for APMs, which can be used to describe and measure progress in the adoption of APMs across the U.S. health care system. This framework was released in January 2016 and is only the first step of the LAN's efforts, which are now focused on patient attribution, financial benchmarking, and clinical episodes, among other topics.³ This example shows that CMS, working with a multitude of partners through the LAN, can help the health care system meet or exceed the Medicare goals for value-based payments and APMs.

¹ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03.html>

² <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03-2.html>

³ <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

We thank Congress for their leadership in passing the bipartisan MACRA, which was signed into law on April 16, 2015. The passage of MACRA supports the ongoing transformation of health care delivery by furthering the development of new Medicare payment and delivery models for physicians and other clinicians. The law repeals the sustainable growth rate formula for updating Medicare physician fee schedule (PFS) payment rates and substitutes a series of specified annual update percentages. It also establishes a new methodology that ties annual PFS payment adjustments to value through a Merit-Based Incentive Payment System (MIPS) for certain eligible professionals (EPs) and creates an incentive program to encourage participation by EPs in certain APMs.

CMS is committed to engaging with stakeholders in implementing this important legislation. In CMS's calendar year 2016 PFS proposed rule, we solicited comments regarding implementation of certain aspects of the MIPS and broadly sought comments on the topics in MACRA, including the framework for providing the incentive payments associated with APM participation. On October 1, 2015, we released a Request for Information (RFI), asking for comments from the stakeholder community on many topics related to MIPS, APMs, quality measurement, and meaningful use of certified electronic health records (EHRs). Further, in December 2015, CMS, in conjunction with the Office of the National Coordinator for Health Information Technology, issued an RFI to assess policy options that could improve the effectiveness of the certification of health information technology and specifically the certification and testing of EHR products used for the reporting of quality measures. We know physicians and other clinicians have a lot of demands on their time, and we are grateful for the robust response from the stakeholder community to these requests for feedback. We are currently in the process of reviewing and incorporating the feedback we received, and we anticipate releasing a proposed MACRA implementation rule, including a 60-day comment period, this spring. We look forward to continued engagement from Congress and the health care community.

Quality Measurement Programs and the Merit-based Incentive Payment System (MIPS)

The provision of quality health care for Medicare beneficiaries is a high priority. Prior to MACRA, Congress established three programs to link payment with quality and value for physicians and other clinicians. Under the Physician Quality Reporting System (PQRS), EPs submit data on quality measures to avoid a payment adjustment. The program originally provided an incentive payment to participants who satisfactorily reported. Beginning in 2015, incentives were replaced with negative payment adjustments for individuals and group practices that do not satisfactorily report data on quality measures or satisfactorily participate in qualified clinical data registries. The Physician Value-based Payment Modifier (VM) applies a payment adjustment based on participants' performance on quality and cost metrics. The VM applied to large group practices in 2015, smaller groups in 2016, and will apply to individual physician EPs and groups in 2017. The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs were established to encourage participants to adopt, implement, upgrade, and demonstrate meaningful use of certified EHR technology. These programs provide incentive payments to participants meaningfully use certified EHR technology, and as of 2015, participants that do not meet the requirements of the Medicare EHR Incentive Program and that do not qualify for a hardship exception receive a negative payment adjustment.

The PQRS, VM, and EHR Incentive Program have each played an important role in the development of physician-based quality measurement and reporting in the Medicare program. MACRA changes and combines these programs for applicable Medicare eligible professionals and accelerates the alignment of measures, program policies, and operations by sunsetting their separate payment adjustments under the PQRS, VM, and EHR Incentive Program at the end of 2018 and establishing the MIPS in their place beginning with payments in 2019. The MIPS is a rigorous value-based purchasing program for physician services. EPs will be scored under MIPS based on a single composite performance score, which will factor in performance in four weighted categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology.

We are working hard to establish the proposed measures and activities that will fall under each of the four MIPS categories and appreciate the feedback we have received from stakeholders to the RFI, particularly regarding areas that are new to CMS, such as clinical practice improvement

activities. We are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population.

In particular, we have been working side by side with physician and consumer communities and have listened to their needs and concerns about the Medicare EHR Incentive Program for EPs as we transition it to MIPS. This work will be guided by several critical principles that promote better care for Medicare beneficiaries:

1. Rewarding providers for the outcomes technology helps them achieve with their patients.
2. Allowing providers the flexibility to customize health IT to their individual practice needs. Technology must be user-centered and support physicians.
3. Leveling the technology playing field to promote innovation, including for start-ups and new entrants, by unlocking electronic health information through open application programming interfaces (APIs) – technology tools that underpin many consumer applications. This way, new apps, analytic tools and plug-ins can be easily connected to so that data can be securely accessed and directed where and when it is needed in order to support patient care.
4. Prioritizing interoperability by implementing federally recognized, national interoperability standards and focusing on real-world uses of technology, like ensuring continuity of care during referrals or finding ways for patients to engage in their own care. We will not tolerate business models that prevent or inhibit the flow of data necessary to meet the needs of the patient.

Payment adjustments under MIPS are scheduled to begin in January 2019. Professionals will receive either a positive, negative, or neutral payment adjustment depending on their performance relative to a pre-established performance threshold. The downward adjustments are generally limited to 4 percent of the physician fee schedule amount in 2019, increasing to 5 percent in 2020, 7 percent in 2021, and 9 percent in 2022 and subsequent years. While the upward adjustments can go above these percentages, the law generally requires the overall adjustments to be budget neutral, so the actual upward adjustments will be scaled in such a way to achieve this budget neutrality. MIPS is designed to give EPs a strong incentive to perform

well and the opportunity to improve their performance over time. In addition, in the first 6 years, Congress made available \$500 million per year for additional positive payment adjustments for EPs with exceptional performance above a higher threshold amount.

While a large majority of Medicare EPs will be required to participate in the MIPS program, Congress established exceptions for EPs in certain situations, including: qualifying participants in certain eligible APMs, who will instead receive the APM incentive payment; professionals in their first year of Medicare participation; partial qualifying participants in certain eligible APMs; and professionals who do not exceed an established low-volume threshold. In addition, MIPS does not apply to hospitals or facilities.

Alternative Payment Models (APMs)

Over the past several years, CMS, through the Center for Medicare and Medicaid Innovation (“the Innovation Center”), has begun implementing many different payment models to test ways to improve the quality and value of care provided to beneficiaries in the Medicare program. Generally speaking, an APM is a model that holds providers accountable for the quality and cost of the care they deliver to a population of patients by providing a financial incentive to coordinate care for their patients. This helps ensure patients receive the appropriate care for their conditions and reduces avoidable hospitalizations, emergency department visits, adverse medication interactions, and other problems caused by inappropriate care or siloed care.

MACRA established a particular definition of APMs and established what qualifies as an “eligible APM,” for purposes of exempting EPs from MIPS and allowing EPs to receive a special incentive payment as a qualifying APM participant. The statute establishes key criteria for these eligible APMs, including that they must require the use of certified EHR technology, base payment on quality measures comparable to those in MIPS, and either place participants at more than nominal financial risk or be a medical home that has been expanded under Innovation Center authority. (Or, in the case of a Medicaid medical home, is a medical home that that meets criteria comparable to medical homes expanded under Innovation Center authority.) EPs who participate in these eligible APMs and meet specified annual payment or patient count thresholds established in the statute are eligible to earn a 5 percent incentive payment for each of the years they meet those thresholds from 2019 to 2024. In this way, MACRA provides incentives to those

physicians and other clinicians committed to operating in very advanced APMs, including those with more than nominal financial risk.

While creating this new category of eligible APMs provides for promising incentives for a growing number of EPs in the future, we expect the initial years to be ones of development as we apply lessons learned and continue to refine the program. As discussed above, the statute creates a high bar for eligible APMs. Many currently existing APMs – at the Innovation Center and in the private sector – are not likely to meet all these requirements, but some will. We will continuously search for opportunities to expand the range of options for participation in eligible APMs within the contours of the statute. In keeping with the statute, it is our intent to align the MIPS and APM components of the new payment system to the extent feasible, thus allowing maximum flexibility for physicians and other clinicians who are not yet ready for eligible APMs to participate in MIPS and then migrate to eligible APMs when they are ready. As we move forward with MACRA implementation, we will continue to gather and incorporate feedback from stakeholders as we promote additional physician-focused APMs.

Physician-Focused Payment Model Technical Advisory Committee

In addition to establishing MIPS and creating new incentives for participation in eligible APMs, Congress established a new independent advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC meets on a periodic basis to review physician-focused payment models submitted by individuals and stakeholder entities and prepare comments and recommendations on proposals that are received, explaining whether models meet criteria for physician-focused payment models. The 11 members of the PTAC, who were appointed by the Comptroller General, are experts in physician-focused payment models and related delivery of care, including researchers, practicing physicians, and other stakeholders. The first PTAC meeting was held on February 1, 2016, and presentations from the meeting are available online.⁴ CMS looks forward to receiving recommendations for new physician-focused payment models. We will need stakeholder engagement with the PTAC, including physicians and other clinicians, to suggest well designed, robust models that could meet the statutory criteria to be an eligible APM.

⁴ <https://aspe.hhs.gov/meetings-physician-focused-payment-model-technical-advisory-committee>

Technical Assistance

We know that physicians and other clinicians may need assistance in transition to the MIPS and we want to make sure that they have the tools they need to succeed in a redesigned system. In addition, Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as regional extension centers and regional health collaboratives to offer guidance and assistance to physicians and other clinicians. The technical assistance is to focus on the performance categories under MIPS, helping to make it as seamless as possible for these clinicians and practices to comply with MIPS requirements and helping interested practices transition to implementation of and participation in an APM. . We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance.

In addition to the MACRA funding, in September 2015, CMS awarded \$685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and spend dollars more wisely. The Transforming Clinical Practice Initiative is one of the largest federal investments designed to support physicians and other clinicians in all 50 states through collaborative and peer-based learning networks.

Conclusion

MACRA will help move Medicare towards rewarding the value and quality of physician services, not just the quantity of such services. As a practicing physician who has also led quality improvement efforts in health systems, I know the importance of quality measurement and improvement. We intend to use a patient-centered approach that leads to better care, smarter spending, improved patient outcomes, and program development that is meaningful, understandable, and flexible for participating clinicians. It is our role and responsibility to continue leading this change and to continue partnering with lawmakers, physicians, and other providers, consumers, and other stakeholders across the nation to make a transformed system a

reality for all Americans. We look forward to working with this Committee, members of Congress, and other stakeholders as we continue to implement this seminal piece of legislation.

Mr. PITTS. Thank you very much for that. We are now voting on the floor, so we are going to start the questioning and then recess and come back. I will begin the questioning and recognize myself 5 minutes for that purpose.

Dr. Conway, MACRA provided great flexibility in its effort to streamline the three major physician quality reporting systems. It did this by sunseting and reconstituting them into a single reporting system, MIPS, Merit-based Incentive program. This provides CMS an opportunity to reevaluate these programs and make changes to them that furthers the legislative goals of coordination and ease of reporting. Administrator Slavitt has made comments regarding meaningful use, for example, that appear to recognize this flexibility.

Question, will CMS embrace this flexibility to eliminate duplicity, reduce redundancy, and increase effectiveness and simplicity in physician reporting?

Dr. CONWAY. We will embrace this flexibility. If it is OK I will add just a bit more. Specifically, we have tried to align various programs on the back end, if you will, of this statute. One of the beauties of the statute is it puts them all, as you said, in one program focused on quality and value.

Specifically, we are looking at each area and how we make it flexible and meaningful to physicians and patients, and on the meaningful use arena we do think the statute gives additional flexibility to really focus on interoperability, outcomes for patients, simplifying the program and making it as meaningful as possible to physicians, clinicians, and the patients they serve.

Mr. PITTS. Would you expand on CMS' plan to develop appropriate awareness among providers of what is required to succeed in MIPS and the APMs.

Dr. CONWAY. Yes. We think this is a critical factor in terms of awareness and engagement of physicians and clinicians both in shaping the program and then ultimately being successful.

I will give you a few of the aspects that we are focused on and working on. One, we want to thank you for the technical assistance funding that you provided especially focused on small rural practices and practices that serve underserved populations. So we think that technical assistance funding will help us support physicians and clinicians to be successful.

We are also broadly, through our QIO program and a Transforming Clinical Practice Initiative, which is over a \$650 million investment over 4 years, trying to support physicians and clinicians to improve quality and lower costs. In addition, I met with AMA yesterday, and we meet with specialty societies all the time about how do we leverage these societies and organizations that physicians and clinicians trust and work with, to work with whether it is GI physicians or ophthalmologists or whatever the special society, really to deeply engage their own set of physicians and clinicians so they understand the program and can be successful.

Mr. PITTS. In the short term, would you describe CMS' approach to quality as more focused on ensuring providers are ready to transition to qualified APM or in simply getting more providers in the value based payment arrangements?

Dr. CONWAY. That is a good question. I think it is both, and then let me describe. So, one, the good news on quality reporting is that many years ago when I started we had a fairly, we had a minority of physicians and clinicians reporting quality. We now in 2014 had over 800,000 eligible professionals, physicians and clinicians reporting in the Physician Quality Reporting System.

This statute allows us to move that to the next stage, if you will, to really have a whole program, as you said, focused on quality and value. The goal is to have not only the vast, have the vast majority as close to all physicians and clinicians as possible to be reporting and reporting successfully and then measuring their value and improving over time.

In addition, as you mentioned, for those physicians and clinicians that want to move to eligible alternative payment models, we want to help them make that transition. And we are really engaging deeply with physician and specialty societies and encouraging them to develop the alternative payment models that may be most relevant to that specialty, bringing those forward to the—sorry to use more acronyms—PTAC committee that was part of the legislation so that they could then make recommendations to CMS.

So we think that deep physician/clinician engagement and enabling those physicians and clinicians when they are ready to make that choice to move into an eligible alternative payment model is a goal. But some physicians and clinicians may choose to stay in MIPS, and that is OK. It is a choice to be made by those physicians and clinicians.

Mr. PITTS. Just very quickly, have physician groups expressed to CMS that they are satisfied with the interaction so far with CMS on MACRA development?

Dr. CONWAY. So I would say we interact significantly with physician and clinician groups. I also think you almost can't do too much. So with any request for an interaction we do have that interaction. I still, to get—it is over a million physicians and clinicians across America, so I think we will need to continue to work on this to really engage down to the front line.

Mr. PITTS. Thank you. We have got 8 minutes left on the floor vote. The chair recognizes Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Chairman. And we are here almost a year after the passage of MACRA. Although it has only been a year, it is important we take a moment to remember how we arrived at this moment. As we know, MACRA Medicare providers were subject to the Sustainable Growth Rate formula, the SGR. Dr. Conway, can you explain the basics of the SGR and why it wasn't working, so we don't repeat it again?

Dr. CONWAY. Yes. So the basic says, where certain targets weren't met, then you were going to have what became more and more dramatic reductions in payments that were a blunt tool. I think the beauty of the legislation is you put in place an overall quality and value program in MIPS and an ability to incentivize quality and value and also the eligible alternative payment models for population health management.

Mr. GREEN. Well, my next question is why was it that Congress deemed necessary to provide a total of 17 temporary patches between 2003 and 2014? I can tell you that because Congressman

Burgess and I were here. It was because we wanted doctors to actually serve Medicare patients and that is the fear of it. How do you foresee that MACRA fixing this perennial issue?

Dr. CONWAY. Yes. I think the MACRA statute does, as you say, is a major steps forward in fixing this issue. I think, specifically, the MIPS program is much more understandable. We will need to think about branding and how we communicate with less acronyms if possible.

But I think when I—I was just talking to a group of GI physicians last week. I think one program makes much more sense to them than individual separate programs. Two, a stable predictable future makes much more sense to them than not knowing what the next year or the next several months might hold in terms of payments.

And then I do think the eligible alternative payment models, we have been excited about the number of physicians and clinicians beginning to think about what is the alternative payment model for their specialty, for their area of practice, and are hopeful that they come forward with many great ideas on eligible alternative payment models.

Mr. GREEN. I think what CMS is doing to reach out to the specialties and of course everyone to get their input in how we can do it. Practice transformation is an expensive and time-consuming process for small practices and few of them have resources to tackle it. Challenges invariably in these practices differ greatly whether the practice is independent or only have one or two physicians and is part of a larger system with physicians as employees. The problems are different for practices that are rural, where the available technical and support resources are scarce, or urban where these resources are so expensive. And what is CMS considering in setting up this program of technical assistance to support small clinical practices for effective participation in both MIPS and APs?

Dr. CONWAY. Yes. So I think you hit on a key issue. This technical support is critical. I actually grew up in not a large town in Texas cared for by a family practice, and many of my family members are in private practice across the U.S.

First, on the funding that was provided, we will look to utilize that funding as described to focus on small rural practices plus practices that serve underserved patient populations, because we think that is a critical set of practices to work with. We will likely do the funding in a way similar to how we have done other funding, where we fund entities and networks that have a history of working with these practices and working with them successfully and are trusted partners.

So things like Partnership for Patients we funded networks that work with hospitals. We are looking at likely funding, putting out an RFP that would fund networks working with these practices that are trusted partners to help them be successful in these programs. And those could be state, regional or national focused on a given specialty area.

Mr. GREEN. Mr. Chairman, I am proud our committee did the work to repeal the SGR, but I also know I am hopefully to have these continual hearings and get reports back from CMS to support systems that CMS envisions and how to ensure that information

feedback provided to clinicians and practices are clear and actionable. So, but anyway, and I will yield back my time.

Mr. PITTS. The chair thanks the gentleman. We still have a couple minutes left on the floor vote, so if it is all right with you we will take a brief recess. We will be right back. The committee stands in recess for floor votes.

[Whereupon, at 10:35 a.m., the subcommittee recessed, to reconvene at 10:56 a.m., the same day.]

Mr. PITTS. We will reconvene the subcommittee hearing, and the chair recognizes Dr. Burgess, 5 minutes, for questions.

Mr. BURGESS. Thank you, Mr. Chairman. Again, thank you, Dr. Conway, for being here.

Can I just ask you a brief question about the Physician Technical Advisory Committee and how you see that interfacing with the CMMI stuff, the center for Medicare and Medicaid improvement? As I understand, with the Physician Technical Advisory Committee there is an obligation to evaluate those things that are brought forward and that the agency is required to respond. Is that correct?

Dr. CONWAY. That is correct.

Mr. BURGESS. So in the request for information that you have had so far, has anything that would trigger the PTAC, has that come up?

Dr. CONWAY. No. So the Physician Technical Advisory Committee, or PTAC, has been established, as you know, and a set of members that very well qualified experts across physicians and non-physicians. We look forward to models being sent forward to the Physician Technical Advisory Committee from physicians, specialty organizations, and others, and then as you say, the PTAC, the advisory committee evaluating those models and then making recommendations to CMS and then we would respond to those recommendations.

But we think that process could yield some excellent models for us to implement. And I think the first stage, which I know we have talked about, but the first stage of that process is critical. The physicians and specialty sides, when I interact with them now I encourage them to start working on what they think those models would be so that they can send them forward to the PTAC for consideration.

Mr. BURGESS. And when, just so I will know, when do you expect that to start occurring?

Dr. CONWAY. Yes. So the Physician Technical Advisory Committee, the Assistant Secretary for Planning and Evaluation is the lead, internally, in the department for convening that committee. What the department has said is that they expect to finalize criteria in the fall and then will be asking for models at that point.

I also, when I meet with physicians, specialty societies and others, I say CMS and CMI can always take input. So we interact on models with groups often, so we are happy to take ideas prior to that time as well.

Mr. BURGESS. Well, as I referenced in my opening statement, I mean, no rollout is perfect and there is always going to be points of friction. Recently, I had an opportunity to go through the Inspector General's report on healthcare.gov, so it was like a walk through memory lane for me.

But with ICD-10 a lot of things that I worried about the implementation of ICD-10, that from what I can tell those problems have been manageable. But one of the takeaways, I think, from the Inspector General's report was the ability to have contingency plans, the ability to have a system that will work in place of the big system if it doesn't work.

So what are we looking at during your transitioning period? What sort of contingencies are you building into the system?

Dr. CONWAY. It is a great question. Mr. Slavitt and myself are working, have a management structure very similar to what we did in ICD-10 where we identify it is a high priority arena. On MACRA implementation we have, literally, weekly meetings, with work in between those meetings with Dashboards, et cetera, to go through where we are in the process and the structure, both the policy and the operations.

Also to your point with contingency plans on if certain aspects of implementation have difficulty what is our contingency plan. As you alluded to, we agree with you that this is a critical, important piece of high priority legislation, so we will manage it that way. I think the last thing—sorry—just to mention similar to ICD-10 we are doing engagement now with physician and clinician groups to help us with the implementation.

Mr. BURGESS. One of the things that is so critical that doctors get into the correct merit-based incentive payment schedule or the eligible alternative payment method, and so you are aware of the fact that you need people to get to where they need to go even if they may not understand how it is they need to get there?

Dr. CONWAY. Yes. I should mention Mandy Cohen is also positioned very active in the management. Yes, we are aware. I think we need to interact in a bidirectional, communicative manner to help outline the pathway and also help people succeed along that pathway, including for eligible alternative payment models if that is the path they choose.

Mr. BURGESS. Mr. Green made fun of the fact that there were so many TLAs—that is three-letter acronyms—in the bill.

Dr. CONWAY. Yes.

Mr. BURGESS. I regret that it was necessary, but sometimes for the economy of language you just have to pursue those, hence, your agency being called CMS, when in fact it is the Center for Medicare & Medicaid Services.

Thank you, Mr. Chairman. I will yield back.

Mr. PITTS. Thank you. The chair recognizes the gentlelady from California, Mrs. Capps, 5 minutes for questions.

Mrs. CAPPS. Thank you, Mr. Chairman. It will be hard for me to top that one. But I appreciate you being here today and for your testimony, and thank you, Chairman Pitts and Ranking Member Pallone, for holding this important hearing.

The passage—well, here goes the acronym—MACRA was the culmination of many years of work to move beyond the flawed SGR. It was an important compromise that showed how well this committee can work when we put aside our differences and focus on a common goal. MACRA passage was a notable achievement that put this on the path to rewarding quality and value instead of just quantity and volume of care.

The only way to truly move to a more quality based system that is accessible to all who need it is to ensure that we have the health care workforce available and engaged in providing the care. And that means we need the engagement of physicians and nonphysician health care providers alike. And I am referring in my questions especially to nurses.

When we think about the delivery of health care and all the innovations taking place in this area, terms such as coordination, patient-centered, integration are often used. These ideas that we are finally starting to realize in the broader health care system have long been the tenets of nursing practice. Patient-centered care, continuity, coordination in cross settings, disease management, patient education, the list goes on. Nurses, especially advanced practice nurses are, by nature of their training and licensure, leaders in these areas.

Dr. Conway, can you elaborate on why it is so important that non-physician providers like nurse practitioners are included, not replacing but included in the delivery care system reform?

Dr. CONWAY. Yes. Thank you for the question. I think the integration of nurses and advanced practice nurses and the whole care team is critical for this success. I can tell you, and it sounds like you know very well that what we are seeing, for example, in our accountable care organizations, our advanced primary care medical homes, they truly operate as an integrated care team, so physicians, nurses, medical assistants, and sometimes community health workers and others across the medical neighborhood focused on population health management.

Both from being married to a nurse and still working with nurses and other health care professionals, that care team aspect and coordination across the care team and leveraging the talents of the entire team are going to be critical to the success in these alternative payment models.

Mrs. CAPPS. Thank you. Nurses, it is my conviction at least that nurses are the backbone of the health care delivery system. Nurses do health care delivery with more than 2.7 million qualified professionals providing care to America's patients, including our nation's servicemen and women.

And more than any other health care provider, nurses spend time at their patient's side whether in the public setting, home setting or acute care, and they monitor the full scope of their care. So they are a critical part of the patient's care team in a variety of settings, as I mentioned earlier, including the emergency room, the health clinic, the long-term care setting, anywhere you might find someone needing medical care, health services, you will be requiring this team approach. That is one of the best parts of what we are discussing today, in my opinion.

So what are some of the ways that nurses are being incorporated into the new innovations that are occurring as a result of MACRA?

Dr. CONWAY. Terrific question. I will just give you a few examples.

Mrs. CAPPS. Sure.

Dr. CONWAY. Our bundled payment initiatives, you have nurses both in hospitals and long-term care settings and others as the primary care coordinator. So we have examples, including successful

entities on bundled payment for things like surgeries or medical procedures, where their critical intervention is nurse care management both in the hospital and then outside the hospital and into the home, so home health nursing, et cetera, as well.

Our Comprehensive Primary Care Initiative practice in rural Arkansas where the physician leadership will talk about the nurse care managers and their nursing care is the critical success factor in their primary care medical home. I could tell you more stories in accountable care organizations than others, but this, the whole health care team, and I think especially nurses, are critical parts of success in these models.

Mrs. CAPPS. And there are some specialized positions within nursing. It is not just one entity. It is a broad spectrum of entities that some come from management, some from delivery of service. It is a very complex model, but also one that with the right kind of coordination is very possible to deliver and cuts down on duplication in so many areas. So we are talking the same language, it sounds like, and I will yield back to the chairman.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the vice chair of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you. Thank you, Mr. Chairman, and I thank you, Dr. Conway, for coming today. I appreciate it.

Recently the agency announced that 30 percent of payments were tied to quality. However, the definition used does not necessarily comport to the definition of qualified alternative payment models under MACRA. So the question is, or a series of questions here.

Do you envision all of these programs as qualified APMs? If not, how many might qualify? And conversely, what are the major issues you see in having these quality linked payment programs qualify as eligible APMs and for the bonus payments provided by the statute?

Dr. CONWAY. Yes. So the definition that the agency has used for eligible alternative payment models is that the provider is accountable for quality and total cost of care for a population, either an ACO could be for year or a bundled payment for an episode of care.

The Health Care Payment Learning and Action Network, actually, which is a public-private partnership including many payers, providers, et cetera, adopted a very similar definition with some subcategories—sorry for the long answer—and one of those subcategories talks about the level of financial risk.

So I think the key, there are some key phrases in the statute that the CMS will have to propose how to define, so one of those in eligible APMs is more than nominal risk. So we will have to define what more than nominal risk means from the statute. We are going to make a proposal on that and we will seek comment on that. That will be a factor in how many of the current alternative payment models, some of which are ones are one-sided risk, currently, so the question will be how do we define more than nominal risk, will be an example of one of the key questions.

Mr. GUTHRIE. OK. And also under MACRA, the first APM payment update is scheduled for 2019. What will CMS identify as the performance period for assessing whether a physician is a qualifying APM participant for the 2019 APM payment update?

Dr. CONWAY. Yes. So a number of the requests for information comments, and the agency is dealing with this now, and as I think you know we will put out a proposed rule this spring, so we are working on that expeditiously now.

Historically, what we have done is had a performance period that is 12 months, then often providers have wanted 3 or 4 months to finish reporting on quality measures, et cetera. So right now, there is a performance period for Physician Quality Reporting System which was 2015, and providers are reporting their quality measures through about the middle of April.

Then there is claims processing, et cetera, to make the payments what ends up being 12 months after the end of the performance period, about eight months after the end of the finishing reporting quality measures, et cetera. We are looking at that now and determining is that the right structure.

I will say, a few years ago we asked physician and clinician groups did they want to do quarterly reporting like hospitals which allows for more rapid feedback. We heard at that time people did not want to do that. They wanted an annual reporting cycle. But we will be making a proposal on the performance period and look forward to your feedback and others about that.

Mr. GUTHRIE. OK. Thanks. And also, some physicians also make us aware that instead of actually driving quality practice and furthering medical information exchange, sometimes Medicare's quality efforts have served to turn providers into click and check data clerks. I think you have heard that as well. What is CMS doing to ensure MIPS is designed with an eye towards driving quality that is relevant to all individual practices?

Dr. CONWAY. Yes. So our goal is for the quality measure programs to enable measurement that is meaningful, and improvement. I will give you an example where I think we are, I was with the GI physicians last week speaking at a conference. Participation in these programs have gone up dramatically. They are using a qualified clinical data registry which they developed and it includes outcome measures that they feel are meaningful for their specialty. And we have deemed that is a qualified data registry and can meet criteria for our programs.

Their participation in that room, 70 to 80 percent of the people, actually, probably 80-plus in that room, nationally a huge percentage of the GI doctors using that registry, and what they reported is that to them it feels seamless. They do clinical care. They do clinical care the way they would with any patient.

It is measuring outcomes, it is giving them feedback, and it is being used for reporting. We need more examples. Ophthalmology, similar, has done that. We need more examples where we work with specialty societies to have measures that are meaningful to them and their physicians and clinicians, and those also can be used for our payment program.

Mr. GUTHRIE. I do have a final question, so I am about to lose time. And my question was rather than one-size-fits-all, the MIPS was designed for you to have these relevance's of individual specialties, and I was going to ask you how CMS is approaching that implementation, and the law allows you. It sounds like you are doing

it by having input. I know I have just ran out of time, but input from the individual specialty, I think, is very important to the—

Dr. CONWAY. OK, if I answer briefly, so yes, input from the various specialties. We have also done some work with specialties and payers on core measure sets for various specialties in aligning across the public and private sector. So those are a few examples we are trying to make this meaningful to the diversity of specialties.

Mr. GUTHRIE. Thank you. Thank you for your answers. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Thank you, Mr. Chairman. Good morning, Dr. Conway.

Dr. CONWAY. Good morning.

Ms. CASTOR. Happy St. Patrick's Day to you.

Dr. CONWAY. Thank you.

Ms. CASTOR. I want to congratulate you and everyone at the agency for the progress that has been made so far. Even before the Congress passed MACRA and it was signed by the President, the agency had already embarked on many of these payment reforms. And it must be very gratifying for it to come to fruition. I know it is for us as we continue to grapple with how we move from volume to value and continue to tackle the challenges of the aging population in the U.S.

The flawed SGR formula was well overdue and it was great that we could bring in as part of the repeal significant reforms. It came with a lot of new changes. One is the way we define and characterize quality in our health care delivery.

One concern that I have heard back home is that the pre-MACRA set of quality measures often became an administrative difficulty for providers to collect and organize and submit. Can you give folks some assurances now on how MIPS will change the quality reporting system for providers, and do you expect MIPS to help providers focus more on patients rather than paperwork?

Dr. CONWAY. Yes, so thank you for the kind words and the question. A few examples, and I do think this is a critical issue. One, I think the flexibility in MIPS allows the agency to lower the burden of reporting, so to make it more meaningful, part of the clinical work flow, et cetera, focus more on outcomes measures less on process.

We will need to continue to have partnership and help from the various physician, clinician and specialty sides. To elaborate a little bit more, we have some great examples of—the ophthalmologists report that 75 percent of ophthalmologists in the country now are using their registry, using it in a way that they find meaningful to their practice and reporting on quality including outcome measures.

We have other specialties that maybe don't have registries or electronic health record mechanisms yet and are still doing G-code claims and mechanisms that people find, and we have evaluated this, less meaningful to quality improvement.

The goal is to maximize electronic health record reporting and registry reporting that is more meaningful for quality improve-

ment, focus on outcome measures that are meaningful to physicians and their patients. And this public-private sector alignment piece, I think, is critical. I used to work for a provider where I had to report quality measures to the various entities that wanted quality measures, so aligning across public and private payers will help physicians report on an aligned set of measures.

Ms. CASTOR. One of the strengths of the law is that it allows some flexibility among the medical specialties. They can have a say in the quality measures that apply to them. On the other hand, we don't want providers to take the easiest pathway. As you move forward with rulemaking, what overarching principles will CMS employ to ensure that there are enough appropriate and relevant quality measures in place?

Dr. CONWAY. Yes, a few things there. Terrific question. One, we are considering how you would have central flexibility in what measures are reported, but still the ability to focus on outcome measures and more cross-cutting measures.

Two, in our qualified clinical data registries and that reporting mechanism, how do you allow flexibility but also the ability, for example, to validate or audit data to ensure that quality improvement is occurring? And we do that in our hospital systems. So it is how do you take some of this learning from the hospital side into the diverse physician side of quality.

And then lastly, on the measure development there was funding in MACRA for measure development, so we plan to utilize that funding to develop the next generation, if you will, of quality measures for physician and clinician measurement.

Ms. CASTOR. Well, I want to thank you again. It is pretty remarkable. I will run into doctors in the grocery store or at various events and they want to jump right in and talk about all these things, and I bet some of my colleagues are experiencing some of the same things.

But the goal eventually is to ensure that our neighbors can live longer and healthier and not just get the test or medicine earlier. I know those are your shared goals too, so I will look forward to collaborating with you on this as we move forward.

Dr. CONWAY. Thank you.

Ms. CASTOR. Thank you very much.

Mr. PITTS. The gentlelady yields back. The chair now recognizes the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman. Welcome, Dr. Conway. Kind of following up on Congressman Guthrie's questions, how many qualified alternative payment methods do you envision once we get into implementation. Do you have a universe? Do you know?

Dr. CONWAY. Yes. So I think the eligible alternative payment models, we will make proposals on this as I said, but I think the eligible alternative payment models, we will have a reasonable set of eligible alternative payment models, I think, in the early years, and we hope that to grow over time.

So I think we talked a bit about a physician technical advisory committee and other methods to have more specialty oriented, eligible alternative payment models over time, but our expectation is we will have a reasonable set of eligible alternative models out of the gate, and then we will work with physicians and clinicians so

those number of models that meet the criteria in the statute grow over time.

Mr. SHIMKUS. And it will again, a mechanism to reevaluate and refine, because obviously modern medicine changes so quickly and so that there would probably be new variables in the process.

Dr. CONWAY. Yes. So yes is the short answer. We think both the list, if you will, of eligible alternative payment models will be refined over time and probably some will be added and some may move off the list, depending, and also the actual models. I mean, this is true of the innovation center models now. We will make adjustments frequently based on feedback.

One of my calls before the hearing this morning was with a provider organization on one of our models giving us feedback that some of the eligibility criteria for the patients in the model may need to be adjusted. So we take that kind of feedback and make adjustments frequently based on feedback from physicians, clinicians or patients or others in the health system.

Mr. SHIMKUS. So for the 2019 APM update, obviously we are not there yet, and if folks are qualified when would a 5 percent distribution be paid? Do you have any idea? Have you gamed that out?

Dr. CONWAY. Yes, so our goal operationally would be to have a performance period that allows us then to make the five percent incentive payments at the start of the given payment period. So our goal would be to have the payments start in the beginning of 2019.

Mr. SHIMKUS. And let me just finish with this one. I was interested in your response on the trying to define nominal risk.

Dr. CONWAY. Yes.

Mr. SHIMKUS. So, and I don't know, Mr. Chairman, if in the report language of the bill if whether there was report language that addressed that at all. Do you know if there was?

Dr. CONWAY. I do not know for sure, sir. We could check on that.

Mr. SHIMKUS. Yes. And my point being obviously, there is always the debate here in Washington about us being specific or being vague and the agency then doing the definition, and which is leading, I think, many of us to say we have to be more precise so that maybe a definition might go awry of the intent of the legislative branch. So we want to be careful that we are not calling you back in and then having this big fight of why was your definition of the nominal risk different than what we intended in the passage of the legislation.

Dr. CONWAY. Yes, so our goal as well would be to align with congressional intent and the statute. Obviously the statute is what we work with from a rulemaking standpoint. So more than nominal risk, we think, is a good guidepost. We will make a proposal based on that statute. Obviously if you have feedback on that proposal, or if at some point you want technical assistance on any statutory changes we would provide that.

Mr. SHIMKUS. OK. Mr. Chairman, that is all I have. Thank you very much. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman, and thank you, Dr. Conway, for joining us today.

Ever since the passage of the Affordable Care Act our nation's health system is in the midst of unprecedented reform and MACRA has accelerated many of these improvements. And one of the reforms that I believe may be among the most crucial is our shift away from paying for volume and towards paying for value.

So, Dr. Conway, the Administration has set goals to rounding Medicare's shift toward alternative payment models. You mentioned this initiative in your testimony, but can you elaborate on CMS's efforts?

Dr. CONWAY. Yes, thank you for the question and I could talk a long time on this so I will try to be brief. I have been working on health system transformation for quite a while, both outside of government and in government, and I think the progress in the last 5 years is substantial, the last 3 to 5 years.

Some of those numbers I gave you would sound like just numbers when you go through them, almost zero percent in alternative payment models to 30 percent. That is 2011 to the beginning of 2016 numbers, so fairly rapid period of time, \$117 billion. And the important part is not just the dollars, but what it means for patients. I mean, we can't recount all the stories, but advanced primary care medical homes where the patients love the care they are receiving, it is well coordinated, they understand what they need to do, and a physician will tell me, I am finally practicing medicine the way I want to after many, many years.

Our ACO models have grown where we are serving almost 9 million Medicare beneficiaries and growing, so a huge number of beneficiaries in accountable care organizations, including my own mother. And so I think the level of transformation that you have enabled through the statutory language CMS has tried to help catalyze, and then importantly, really driven by states, communities, providers, people moving forward and helping drive the change, I think it has made our care system quality results, over 90 percent of our quality measures improved significantly in the last 3 years.

Safety results, safer in the hospital today than previously; cost results, lowest cost growth in many years. We have got to keep going though. There is more work to do and we want to do that with you. But I think the opportunity here for improvement on behalf of patients in the system is huge. We have made a lot of progress and we will have to continue to accelerate that progress. Sorry for the long answer.

Mr. PALLONE. No, that is all right. In that vein I know you have mentioned that CMS has already mentioned its first benchmarks, achieving the 30 percent payments through alternative payment models this year, but just give me some more information about efforts undertaken that build on this momentum.

Dr. CONWAY. Yes, so I think we have a number of new models. We do have a goal by the way to achieve at least 50 percent by the end of 2018, so we are still on that trajectory. I think a number of new models we are excited about. We have a model for episode-based payment for joint replacement that will be starting April 1st. When I interact with hospitals and physicians and they say what that means to them in terms of coordinating care across a 90-day

episode for a patient that needs a hip and knee replacement, which is a very common procedure in Medicare, I think a huge opportunity for improvement. And we saw that in an earlier model on hip and knee where it improved quality, lower cost.

We have an oncology model we are hoping to announce, the oncologists that came forward, but a very robust response from oncologists saying they want to do episode based care for oncology cancer care, deliver the care they know is better. And they are partnering with us and other payers so that is a multi-payer model.

So we think there is a number—so both of those will add to the alternative payment model numbers I gave you and are just a few examples of how we think these programs and alternative payment models will continue to expand over time and improve care for patients.

Mr. PALLONE. OK. And I only have a minute left. But one issue that hasn't been raised as much here today is the alignment between Medicare and Medicaid. MACRA specifies a participation and certain Medicaid payment models could allow a provider to meet Medicare's all-payer APM targets. Is alignment between Medicare MIPS and APMs and Medicaid a priority for CMS?

Dr. CONWAY. Yes, definitely, and I will even broaden it a bit, alignment between Medicare and Medicaid and commercial insurers as well. So I think we are doing a lot of work at the state level, for example, and nationally to align on quality measures on approach to payment models. Our Health Care Payment Learning and Action Network has put out proposals on alignment for ACOs, alignment in bundled payment. We think that Medicare, Medicaid and private sector alignment is critical to success.

Mr. PALLONE. All right. Thanks a lot. Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. BUCSHON. Thank you, Mr. Chairman, a couple comments and then a quick question. I think Congressman Shimkus talked about Congress and its prescriptiveness and as it relates to PTAC recommendations. We will be following that as you probably know in seeing where CMS is, and if CMS turns out repeatedly and really doesn't follow, take or follow some of the recommendations, then we may even need to ask further questions about that and have more prescriptive legislation involved.

The other thing is, and we mentioned this at Doctors Caucus a few months or so ago, I would encourage CMS to consider pausing the meaningful use program implementation and reassessing how physician practices and hospital systems are able to comply in a cost effective manner. I hear a lot about that.

And it is good that you are continuing to work with stakeholders on what determines quality. I think that is extremely important as a physician that you continue to do that and I appreciate that it appears that you are doing a really fine job doing that.

On the reimbursement, it appears that the Relative Value Scale Update Committee recommendations on reimbursement have not been followed very closely over the last few years. Specifically, more recently in ophthalmology, but historically, pain management, cardiac surgery and others. And I would encourage CMS to take a revisit of these recommendations that have a result—what

CMS has done has resulted in significant payment cuts to providers and the question is, why is that? Why the Relative Value Scale Update Committee recommendations have not been followed more closely. That is a question.

Dr. CONWAY. So on the last one, I will have to look into that more specifically in the specific codes and recommendations—

Mr. BUCSHON. Yes.

Dr. CONWAY [continuing]. And we can get back to you, sir.

Mr. BUCSHON. Appreciate that. And then a recent study in health affairs found that physicians spend about \$15 billion a year on quality reporting, hopefully this will be better under MIPS. Is CMS conducting an assessment of costs and administrative burdens associated with physician compliance? That is the first question.

And if not, is this something CMS might embark on especially as a means to judge MIPS' future success in reducing this financial burden? So it costs a lot of money to comply, so are there things that CMS is looking at to try to improve that?

Dr. CONWAY. Yes, so we are trying to lower the burden of reporting. We think mechanisms to get there are things like qualified clinical data registries and other aspects that more seamlessly integrate with the physician and clinician work flow. And we do think lowering the burden, increasing flexibility, simplicity, but still focusing on outcome measures that are meaningful, are critical to success.

Mr. BUCSHON. By the way, I am a big supporter of quality measures and payment based on value and success. It is just critical of course that physician groups and other stakeholders are part of what determines that and also make their ability to report in a timely and appropriate manner less costly and more efficient. Those are really important.

The last question I have is, are large hospital systems pushing for CMS for so-called single check payment from CMS for provider services? Do you know what I mean by that?

Dr. CONWAY. Do you mean global budget?

Mr. BUCSHON. Yes.

Dr. CONWAY. So we have some states that have asked us with their hospitals to think about global budgets in those states for a subset of interested hospitals.

Mr. BUCSHON. OK, because the orthopedic things you talked about are starting to lean towards that. Look, I am all for efficient coordination of care, decreasing costs and improving patient outcomes. The question is, is whether or not a global budget like that, a so-called single check to a hospital system for all services provided, from a physician's perspective, will be something that could be successful because it all depends on a lot of internal negotiations amongst the hospital and their provider network, providers themselves. And it almost continues to help eliminate the independent practice model from a physician perspective. Do you have any comments on that?

Dr. CONWAY. Yes. We think the independent practice model of physicians and clinicians is important and important to delivery system reform. Two, in some of our bundle payment mechanisms we specifically enable gain sharing and other mechanisms to try to

make sure that physician engagement is deep. And lastly, the entities that are successful generally have a deeply engaged physician and clinician workforce.

Mr. BUCSHON. OK. Again, I would like to interact with you on a couple issues, the pause in the meaningful use and what your thoughts are on that at some time outside of a committee hearing, and also the RUC recommendations and why it appears over the last number of years that those haven't really been taken into serious account when reimbursement decisions are being made at CMS.

Thank you. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Thank you. Good morning, Dr. Conway.

Dr. CONWAY. Good morning.

Mr. MURPHY. Just to be clear, the models we are talking about here for payments on things, they are there to incentivize doctors to do the most effective and efficient care and reward them for good decisions.

Now one of the areas that what I get concerned about this is CMS policies restrict doctors from making decisions. And so I want to lay out a couple things that I hope CMS reviews, because it is great if we empower doctors to do the best thing, it is a problem if we say, please do the best thing, by the way we aren't going to let you do it, particularly for people on Medicare and Medicaid.

We have had hearings before on the issue, for example, protected class of drugs. My understanding is there is still a move in CMS to eliminate psychiatric drugs as part of this protected class, but you may be aware that with protected class of psychotropic drugs antidepressants may all be antidepressants, but because of side effects some people will stop taking them. And yet, if that drug, the new drug is not covered that it doesn't do any good, so the physician is trying to make a decision but his hands are tied.

There is also an issue with—and I know, look, we did what we needed to do with SGR and we have this, with this act which is now a month ago we passed this bill and we have about 73 billion in offsets, and net costs may be 141 billion and we are hoping to find all the money for that but still, we recognize the value of that.

But I have been working on mental health reform now for a couple of years. This committee has been dealing with this, but there still is an IMD exclusion in this with CMS. We used to have 500,000 psych beds in this country in the 1950s and now we have less than 40,000. We need 100,000, because people with an acute phase of psychotic break need a place to go besides a five-point tie down in an emergency room or being put in jail or being sent to the county morgue. But people with serious mental illness not in treatment are at a high risk for suicide, violence, et cetera.

Now the consequence not treating mental illness according to NIMH, even back in 2010, was pretty staggering. Fifty percent of individuals with a serious mental illness have a chronic illness, at least two, and 40 percent of them don't receive any treatment in any given year.

Additionally, Medicaid reports show that the extraordinary role of mental illness in multi-morbid illnesses that five percent of people in a Medicaid population account for 55 percent of the costs of Medicaid, and virtually all of those have a mental illness.

And so, and also with people with delusions and hallucinations, the longer they go without treatment the worse it gets. The longer a person waits for treatment for a psychotic episode the longer it takes to get the illness under control. For bipolar disorders, the sooner a person gets on lithium or other treatments the better their treatment goes.

So, but what happens here is we have this wide range of people with serious mental illness who are SSI and SSD recipients and the cost of untreated mental illness is pretty amazing. I mean, the cost of untreated diabetes, which many of them have particularly if they are taking second generation antipsychotics, costs of untreated diabetes is \$245 billion per year in this country, \$176 billion in direct medical costs. And that is why it is so important for many people with serious mental illness to get treatment early on.

I want to make sure that as we are approaching this that whether it is Medicare or Medicaid, anything within CMS' realm, let doctors treat patients. But when we come up with rules that say you can't prescribe what is most effective, you can't let them stay in the hospital more than 16 days, 16 beds, and you can't see two doctors on the same day, this is without CMS not certainly Medicare, but it is all our money.

So I look here with the high numbers we have for cardiovascular disease, pulmonary disease, infectious disease, all which have a higher mortality rate, higher morbidity rate, we have to change this. So although I am pleased this committee worked to get doctors paid more, we have to make sure that policies associated with this do not tie their hands with CMS policies that prevent them from getting them into acute care, making sure we address that quickly, making sure we have the medications available for them.

So along those lines, when we saw that CBO actually scored this they said that we don't know how to score this. They simply came up with the numbers and said, well, let's just multiply the number of hospital beds in this country, psych beds 147 million, whatever that is, times the cost and they came up with this staggering number, but saying we really don't know how to do this.

I know CMS is also looking at other avenues for this, for example, in managed care programs to do something like a 15-day length of stay. If we made it an average length of stay, that would help. But I am just asking you, take that information back, work this out.

Missouri actually did a study that says when you lift that 16-bed rule you actually save about 40 percent in the federal area. It is a huge savings. And I guess I come down to this. If we have all this money to pay doctors, we ought to be able to come up with a few billion dollars to treat patients. And so I want you to take that message back as you work these things out. Please make sure we allow the mentally ill to be treated. Please make sure that doctors' hands aren't tied. And as you are looking at incentives, make sure you are not preventing the actions from taking place. Thank you.

Dr. CONWAY. Great.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it very much. First question is, has CMS done any modeling if commercial insurance is using value based products and payment arrangements similar to CMS' proposed alternative payment models? Do you envision that Medicare Advantage would or could count towards a provider's alternative payment model performance threshold?

Dr. CONWAY. Yes. So we work closely with Medicare Advantage and other commercial plans. The various plans are implementing many of the same models CMS is, accountable care organizations, bundled payment, advanced primary care medical homes. We are actually now doing work with the health plans. We did quality measure alignment work, but now through what is called our Health Care Payment Learning and Action Network we are also aligning on things like risk adjustment, attribution, data. Once again we obviously can't force alignment, but we are having discussions around these various payment models and how we align.

In terms of Medicare Advantage, as you know, in the statute there is the multi-payer, all payer provisions starting in the 2021 payment. So that would allow us to look across not just traditional Medicare, but also payments to providers from other commercial plans including Medicaid and Medicare Advantage. And we will have to propose the details of that but the statute is flexible in its focus across multi-payers.

Mr. BILIRAKIS. Thank you, next question. One area that is addressed by MACRA but will require significance guidance by CMS is physician participation in multiple alternative payment models. We wanted physicians to be able to experiment with different approaches to improve their practices while also recognizing that the many APMs being developed by stakeholders are narrowly focused on a specific disease or condition.

How might CMS approach the issue of a physician wanting to participate in multiple APMs while seeking to avoid MIPS' penalty through noncompliance, and then will CMS consider APM participation in the aggregate when determining if a physician reaches the performance threshold?

Dr. CONWAY. Yes. So we are looking at this issue now and have heard it from physicians and clinicians as well about wanting the desire to potentially participate in multiple eligible APMs. As you know, part of this is driven by there are percentages for payments and/or patients in the statute, 25 percent initially and then going up over time. So one of the issues we have heard from physicians and clinicians is they may want multiple eligible alternative payment models to try to meet those thresholds.

So we are looking at this now, how would we do this operationally, how would we allow that to occur. To go back to principles, our goal is to allow physicians and clinicians to practice medicine and to practice it the way they choose and to allow multiple paths to success, so that physicians and clinicians can select whether it is MIPS or eligible alternative payment models, the models that are most meaningful to their clinical practice. So those are a few thoughts on that sir.

Mr. BILIRAKIS. Well, thank you very much. I yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from Indiana, Mrs. Brooks, 5 minutes for questions.

Mrs. BROOKS. Thank you. An overarching problem with the current physician quality programs is attribution. And physicians have communicated to the committee that they get attributed to patients' costs and outcomes of the physician have little or nothing to do with. At the same time, other physicians don't have any patients attributed to them at all. And so what is CMS doing to fix the attribution problem as it implements MIPS?

Dr. CONWAY. So we are doing a number of things to work on attribution. I think for a number of our payment models we have dealt with the attribution issue for a longer period of time, like accountable care organizations where we have things like plurality of visits, et cetera, and have dealt with some of the specialty issues on attribution. Similar in primary care, for bundles we often have a primary attribution mechanism.

Where it becomes challenging and you are alluding to in the MIPS arena, is in a traditional fee-for-service environment where patients are seeing very many different physicians and clinicians how we do attribution. We do think the statute has some guideposts there that are helpful. You included language, as you know, on physicians and clinicians being able to identify their relationship with patients, which we think is intriguing, and we are looking at how you might implement that so physicians and clinicians are directly engaging in attribution.

You also included language on virtual groups, which is complex but an interesting area of the statute to think about how you might enable physicians and clinicians to make choices about virtual groups or enable virtual groups based on the data.

So I think attribution will continue to evolve. This actually was in our discussions we have had with other private payers. But evolve in a way we think it will continue to improve over time and also enable the ability to physicians and clinicians to engage in the attribution issue.

Mrs. BROOKS. As the law encourages coordination of care and the growth of medical homes, what is your current thinking then of how to attribute patients to a primary care practice specifically in order to determine their health outcomes?

Dr. CONWAY. So our current methodology is often based on plurality of visits to a primary care doctor. We are actually experimenting now in testing new methods. So in our ACO models now we are testing what is called voluntary attribution, but essentially the patient says this is my doctor, and then they are attributed to that doctor. We think that has a lot of promise. We are still testing how to do that best and how to make sure patients and physicians understand it, but we think that idea of voluntary attribution can be helpful.

A number of our models now have prospective attribution so people know their patient population ahead of time. In our next generation ACO model which just launched in January they get prospective attribution of those organizations, many of which are physician led. They have the ability to do voluntary attribution so the

patient is saying I am in this model, this is my doctor, this is my provider. They also have things like telehealth waivers and other things to help them succeed.

But I think you can look at some of our leading edge models, if you will, to see where we think we can go in attribution and overall these new payment models.

Mrs. BROOKS. What criteria is CMS using to determine the eligibility of specific medical homes?

Dr. CONWAY. For eligible APMs you mean?

Mrs. BROOKS. Yes.

Dr. CONWAY. Yes. So, as you know, the statute specifically called out if a primary care medical home was expanded using the CMMI authority that that would be an eligible APM. We do not have any models yet from the innovation center that have been expanded. We do have Comprehensive Primary Care Initiative which has shown decreased hospitalizations, decreased ER visits, positive quality of care results, but has not yet met the—our actuary would need to certify that model for it to be expanded. That has not occurred yet because it is still in the first couple years of the model.

We also could make proposals on primary care medical homes that could allow new models, whether they are CMS-run or run by others or brought to us by others like physician groups, to qualify as an eligible alternative payment model.

Mrs. BROOKS. So you are open to having new definitions and new criteria brought to you with respect to medical homes?

Dr. CONWAY. Yes, and you could certainly comment on congressional intent if you want to. It was called out separately in the statute which we read as, and a number of members have mentioned today, the focus on primary care. So we are trying to adhere to both the statute and what we think was meant. And we know primary care is critical to health system transformation, so we need robust primary care models that allow primary care physicians and clinicians to participate and be a foundation for delivery system reform.

Mrs. BROOKS. Thank you. I have nothing further, Mr. Chairman, yield back.

Mr. PITTS. The chair thanks the gentlelady. That concludes the first round of questions. We are going to go to one follow-up per side, and the chair recognizes Dr. Burgess for a follow-up.

Mr. BURGESS. Thank you, Mr. Chairman. I appreciate the courtesy. Thank you, Dr. Conway, for staying with us this morning. Let me just ask you a couple of questions about the electronic health records side of this.

Underlying legislation kind of envisions clinical data registries and certified electronic health records serving as the reporting mechanism for providers to interact with the Medicare program. Could you give us an idea about your agency's work in ensuring that these systems are able to serve the reporting functions envisioned by the legislation?

Dr. CONWAY. Yes. Thank you, Doctor, for the question.

A few things that we are doing, I think, one, working on the electronic health record space first. As I mentioned, we think MIPS and the MACRA legislation allows us additional flexibility to focus on interoperability, simplicity, outcomes. We are working with the

Office of the National Coordinator, as I know you know Dr. DeSalvo, on a few areas. One, standards and really having common standards that are used. Two, making sure that the program increasingly focuses on this interoperability issue which is a critical function. Three, ONC did just come out with a rule around their ability to oversee electronic health record vendors, et cetera. Four, you put in the MACRA statute around data blocking, which we agree with you can be a major issue, and the ability for providers to need to attest that there is not data blocking going on as well.

We think some of the changes like application program interfaces, not to get too technical, but some of the new standards that may allow application developers and apps and others to build on top of electronic health records including registries, be able to pull data and then report that information, we think has serious potential.

And a number—sorry for the long answer—a number of the specialties that I mentioned, like GI and ophthalmology and others that have effective registries, often can pull information from electronic health record, maybe combine that with other information and then use it to report, which we think is a viable, exciting pathway.

Mr. BURGESS. Very well. A statement was made earlier in the hearing that this was a bill passed so the doctors could be paid more. I just respectfully would disagree with that philosophically. There were bills that were required to pay doctors more. Those were called doc fixes, and we passed one every year that I was here for 13 years. It cost a tremendous amount of money, did nothing about the underlying payment system. Well, did a few things around the margins and perhaps made things a little more onerous without really trying to take a global approach to improving the payment structure.

And as I outlined in my opening statement this was a disruptive action, I recognize that and I have heard from a lot of my peers that they are nervous about some of the things we are doing, but I do believe it was in the best interest of continuing to be able to provide Medicare services. So really, this bill was not a bill aimed at paying doctors more, this was a bill aimed at maintaining access for Medicare patients to their physicians, hence the name, Medicare access.

So I appreciate while people are concerned and I get a number of people pushing back on the overall cost, and once again I would just ensure people, the cost of doing nothing, the no-billed scenario, if you will, was about a billion dollars more over 10 years than what we are doing today, and we do have the opportunity to try to put some of the building blocks in place that allows for the sustainability of the program in the years to come.

Look, if I had just been able to do this the way I would have wanted, I would have simply directed CMS to pay whatever bills come in over the transom and stop bothering everybody. But we all know that wasn't a realistic approach. And I promise you, I hear from a lot of my cohort that that is where we should have been on this.

But I do respect the work that you are doing, and I hope that—I mean, I know that we are going to see you back here in the sub-

committee and I look forward to that. I look forward to learning how you are making the process better for everyone involved.

Thanks, Mr. Chairman. I will yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member, Mr. Green, for a follow-up.

Mr. GREEN. Thank you, Mr. Chairman. And following up on my colleague from Texas, and I agree, it was Medicare access. And granted, whatever Medicare rate may not even pay the cost of the physician, but it is part of a physician's practice. In every doctor I have ever met, I just want to practice, they tell me, I just want to practice medicine. I don't need to get rich, I just want to practice medicine and heal people.

Let me ask a follow-up also on as we transition to value based payments it is clear that technology must play the increasing large role. Recently, Acting Administrator Slavitt has admitted some limitations in the current meaningful use program and stated it will now be effectively over and replaced with something better.

Dr. Conway, given that meaningful use of certified EHR technology will remain part of the MIPS score, what broad parameters does CMS intend to use to guide its future approach to the use of health IT?

Dr. CONWAY. Yes, so the broad parameters and principles that both Acting Administrator Slavitt and I and others have discussed from CMS are few. Number one, and we do think the MACRA statute allows us to evolve the electronic health record program for physicians and clinicians in a very positive direction.

The principles are, one, flexibility so that the electronic health record can be used for the diversity of physician and clinician practice. Two, simplicity so that it really focuses on the aspects that matter most. Three, interoperability so that the information is truly flowing across systems.

And then four, what I will call, what we call user design and interface. That the technology is increasingly usable, integrated into the work flow of a physician or clinician in a seamless fashion, which we think there is still opportunities and this is shared between CMS and the Office of the National Coordinator and obviously vendors working with physicians and clinicians so that user interface is as easy to use as possible.

Mr. GREEN. Well, I am glad you mentioned that. And my next question was MACRA gives CMS the flexibility to reform the program because that is one of the concerns. And again, we will be visiting over the next number of months in following what CMS says. I appreciate your perspective and hope the committee will continue a collaborative relationship with CMS to advance the health IT infrastructure in moving forward.

So Mr. Chairman, I yield back.

Mr. PITTS. The chair thanks the gentleman. That concludes the questions of members present. We will have follow-up questions. We will send them to you in writing. We ask that you please respond promptly. A reminder, that members have ten business days to submit questions for the record, so they should submit their questions by the close of business on Thursday, March the 31st.

Dr. Conway, thank you very much. Very good hearing. Very important issue. We will continue to monitor this, and thank you. We look forward to working with you.

Dr. CONWAY. Thank you.

Mr. PITTS. Without objection, the subcommittee hearing is adjourned.

[Whereupon, at 11:53 a.m., the subcommittee adjourned.]

[Material submitted for inclusion in the record follows:]



800 10th Street, NW
 Two CityCenter, Suite 400
 Washington, DC 20001-4956
 (202) 638-1100 Phone
 www.aha.org

Statement
 of the
 American Hospital Association
 before the
 Subcommittee on Health
 of the
 Committee on Energy and Commerce
 of the
 U.S. House of Representatives

March 17, 2016

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

The implementation of MACRA will have a significant impact not only on physicians, but also on the hospitals with whom they partner. According to the AHA Annual Survey, hospitals employed nearly 245,000 physicians in 2013, and had individual or group contractual arrangements with at least 296,000 more physicians. Hospitals that employ physicians directly may bear the cost of the implementation of and ongoing compliance with the new physician performance reporting requirements under the Merit-based Incentive Payment System (MIPS), as well as be at risk for any payment adjustments. Moreover, hospitals may be called upon to participate in alternative payment models (APMs) so that the physicians with whom they partner can qualify for the bonus payment and exemption from MIPS reporting requirements that accompanies the APM “track.”

For these reasons, the AHA is holding ongoing conversations with our membership, and has convened a clinical advisory group to identify the most important policy and operational implications of the MIPS and APMs for hospitals. We look forward to sharing additional insights with Congress and the Centers for Medicare & Medicaid Services (CMS) in the coming months. In the interim, we offer several overarching recommendations on



implementing the MIPS and 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 new payment models – improving quality, outcomes and efficiency in the delivery of patient care.

MIPS IMPLEMENTATION

The AHA urges the adoption of a MIPS that measures providers fairly, minimizes unnecessary data collection and reporting burden, focuses on important quality issues, and promotes collaboration across the silos of the health care delivery system. To achieve this desired state, we believe CMS should:

- Focus the MIPS measures required for reporting on national priority areas and consider limiting the number of measure reporting options over time;
- Employ risk adjustment rigorously – including sociodemographic adjustment, where appropriate – to ensure providers do not perform poorly in the MIPS simply because they care for more complex patients;
- Allow hospital-based physicians to use their hospital’s quality reporting and pay-for-performance program measure performance in the MIPS; and
- Align Electronic Health Record (EHR) Incentive Program changes for physicians with those of eligible hospitals, and refrain from adopting an “all-or-nothing” scoring approach.

Streamlining Measures and Data Reporting Options. **The AHA believes the implementation of the MIPS is a critically important opportunity to streamline and refocus physician quality measurement efforts so they align with concrete national priority areas for improvement across the entire health care system.** There are more than 250 individual measures in the current-law Physician Quality Reporting System (PQRS) and Value-based Payment Modifier programs that affect payment for calendar year (CY) 2017. While the volume of measures stems partially from the need to have measures relevant to the variety of specialties participating in these programs, we are concerned that measures have proliferated without a well-articulated link to specific national priorities or goals. Regardless of the specialty, the significant improvement in outcomes and health that patients expect and deserve is best achieved when *all* parties in the health care system are working toward the achievement of the same objectives.

For this reason, we have urged CMS to use the recommendations of the National Academy of Medicine’s (NAM) *Vital Signs* report to identify the highest priority measures for development and implementation in the MIPS. The *Vital Signs* report notes that progress in improving the quality of health care has been stymied by discordant, uncoordinated measurement requirements from CMS and others. To ensure that all parts of the health care system – hospitals, physicians, the federal government, private payers and others – are working in concert to address priority issues, the *Vital Signs* report recommends 15 “Core Measure” areas, with 39 associated

priority measures. These areas represent the current best opportunities to drive better health and better care, based on a comprehensive review of available literature. Each stakeholder would be measured on the areas most relevant to their role in achieving common goals and objectives. While we caution against using the core measure areas to assess providers on aspects of care that may be beyond the scope of their operations, the NAM report provides an important uniting framework that will help make all stakeholders more accountable and engaged in measurement and improvement.

The AHA also urges the adoption of a limited number of measure data reporting options over time. The existing PQRS includes seven different measure data reporting options, including two different kinds of registries, EHRs, claims-based reporting and a web interface. We believe the proliferation of PQRS reporting options stems from a well-intentioned desire to provide a multitude of ways for physicians to report data, thereby avoiding payment penalties. Nevertheless, the wide variation in reporting options may impinge upon CMS's ability to compare performance accurately in the MIPS. There are clear indications that, even when reporting on the same quality measures, measure results may vary across the different reporting mechanisms. For example, CMS began to calculate separate performance benchmarks for physicians and groups reporting measures using EHRs due to concerns that EHR-derived measure results differ from other data collection modes. To minimize disruption, the agency likely should retain most or all of the existing PQRS measure reporting options in this initial years of the MIPS. However, CMS should undertake further study to determine which submission modes most appropriately balance data accuracy and provider burden.

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

CMS must be especially attentive to the impact of sociodemographic factors on performance measures used in the MIPS and APMs, and incorporate sociodemographic adjustment when necessary and appropriate. The evidence continues to mount that sociodemographic factors beyond providers' control – such as the availability of primary care, physical therapy, easy access to medications and appropriate food, and other supportive services – influence performance on outcome measures. For example, in January 2016, NAM released the first in a planned series of reports that identifies "social risk factors" affecting the health outcomes of Medicare beneficiaries and methods to account for these factors in Medicare payment programs. Through a comprehensive review of available literature, the NAM's expert panel found evidence that a wide variety of social risk factors may influence performance on certain health care outcome measures such as readmissions, costs and patient experience of care.

These community issues are reflected in readily available proxy data on socioeconomic status, such as U.S. Census-derived data on income and education level, and claims-derived data on the proportion of patients dually eligible for Medicare and Medicaid. The agency also recently proposed to adjust several measures in the Medicare Advantage Star Rating program for sociodemographic factors. Yet, to date, CMS has resisted calls to incorporate sociodemographic adjustment into the quality measurement programs for hospitals.

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

Develop a MIPS Participation Option for Hospital-based Physicians. The MACRA includes a provision allowing CMS to develop MIPS participation options for hospital-based physicians to use their hospital's CMS quality and resource use measure performance in the MIPS. **The AHA strongly supports the implementation of such an option in the MIPS, and believes it would help physicians and hospitals align quality improvement goals and processes across the care continuum.** We recognize that the agency will need to establish a process for hospitals and physicians to designate themselves for this participation option, as well as parameters to ensure there is an adequately strong relationship between the hospitals and physicians. For example, CMS could require active membership on the medical staff or an employment contract. The agency could potentially validate the relationship using claims data elements, such as inpatient and hospital outpatient department place of service codes.

EHR Incentive Program Requirements and Performance in the MIPS. The incorporation of the Medicare EHR Incentive Program for Eligible Professionals (EPs) into the MIPS presents an opportunity for CMS to improve the program in a number of ways. **First, the AHA urges the use of a methodology that does not score the MIPS' EHR Incentive Program category using an "all-or-nothing" approach. That is, CMS should not require EPs to meet all of the meaningful use objectives and measures in order to receive points in the category.** Instead, we recommend that attainment of 70 percent of the objectives and measures in meaningful use afford an EP with full credit under this category. Additionally, to the extent that CMS modifies the definitions, structure and reporting requirements of the EHR Incentive Program in the development of metrics for the MIPS and APMs, **the AHA recommends the agency apply such modifications in a consistent manner for all EHR Incentive Program participants – EPs, eligible hospitals and critical access hospitals.** This alignment is critical to ensuring the ability to share information and improve care coordination among providers across the continuum. Lastly, CMS should use its flexibility under the statute to reorient the EHR Incentive Program so that the use of certified technology supports the achievement of national quality improvement priorities.

ALTERNATIVE PAYMENT MODEL IMPLEMENTATION

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

Despite the progress made to date, the field as a whole is still learning how to effectively transform care delivery. There have been a limited number of APMs introduced so far, and existing models have not provided participation opportunities evenly across physician specialties. Therefore, many physicians may be exploring APMs for the first time. **As a general principle, the AHA believes the APM provisions of the MACRA should be implemented in a broad manner that provides the greatest opportunity for physicians who so choose to become qualifying APM participants.** Particularly in the early years of MACRA implementation, the agency should take an expansive approach that encourages and rewards physicians who demonstrate movement toward APMs.

In particular, CMS should adopt an expansive definition of “financial risk” when identifying APMs that “count” for purposes of the MACRA bonus payment. Specifically, CMS’s definition of “financial risk” should go beyond simply requiring an entity to take on downside risk; it also should recognize the significant up-front investment that must be made by providers who develop and implement APMs. Providers who participate in APMs invest significant time, energy and resources to develop the clinical and operational infrastructures necessary to better manage patient care. For example, an AHA analysis estimated start-up costs of \$11.6 million for a small ACO and \$26.1 million for a medium ACO. If CMS does not acknowledge this type of significant up-front investment as the organizational risk that it is, and instead defines “financial risk” very narrowly to require downside risk, the 99 percent of ACOs that participate in Track 1 of the Medicare Shared Savings Program would not qualify.

The AHA believes that such a result is undesirable and at odds with the MACRA’s clear goal of rewarding those physicians who have been early adopters of APMs. In addition, this could inhibit physician movement toward APMs, particularly in early years, if physicians cannot engage with existing model participants – which have a head start on building infrastructure and engaging in care redesign – and instead must start from scratch. While we acknowledge CMS’s interest in encouraging providers to move toward accepting increased risk, such an interest must be balanced with the reality that providers are starting at different points, and will have different learning curves. CMS should define “financial risk” in a way that provides a path for physicians who are interested in participating in risk-bearing models – particularly those who are exploring such models for the first time – rather than serving as a barrier to entry.

Finally, given the increasing prevalence of Medicare Advantage (MA), the AHA urges CMS to explore ways to capture risk-sharing arrangements for care provided to beneficiaries enrolled in MA plans in the APM framework.

LEGAL IMPEDIMENTS TO IMPLEMENTATION OF NEW PAYMENT MODELS

By tying a portion of most physicians' Medicare payments to performance on specified metrics and encouraging physician participation in APMs, the MACRA marks another step in hospitals', physicians' and other health care providers' movement to a value-based paradigm from a volume-based approach. To achieve the efficiencies and care improvement goals of the new payment models, 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.

To do that, a legal safe zone for those efforts is needed that cuts across the fraud and abuse laws – specifically, the physician self-referral (Stark) law, anti-kickback statute and certain civil monetary penalties (CMPs). In our view, these laws are not suited to the new models. The statutes and their complex regulatory framework are designed to keep hospitals and physicians apart – the antithesis of the new models.

To us the answer seems clear: Congress should adopt a single, broad exception that cuts across the Stark law, the anti-kickback statute and relevant CMPs for financial relationships designed to foster collaboration in the delivery of health care and incentivize and reward efficiencies and improvements in care. We recommend that the exception be created under the anti-kickback statute and arrangements protected under the exception be deemed compliant with the Stark law and relevant CMPs.

House Energy & Commerce Subcommittee on Health
 Hearing: "Medicare Access and CHIP Reauthorization Act of 2015: Examining
 Implementation of Medicare Payment Reforms."

March 17, 2016

American Academy of Dermatology Association

Statement for the Record

Chairman Pitts and Ranking Member Green, the American Academy of Dermatology Association (Academy), which represents more than 13,500 dermatologists nationwide, commends you for holding a hearing regarding the Medicare Access and CHIP Reauthorization Act of 2016 (MACRA), especially as all stakeholders work towards a successful implementation over the coming years. The Academy is committed to excellence in medical and surgical treatment of skin disease; advocating high standards in clinical practice, education, and research in dermatology and dermatopathology; and supporting and enhancing patient care to reduce the burden of disease. We applaud you for continuing to monitor the implementation of MACRA and ensuring that the needs of physicians and other healthcare providers, as well as those of our patients, are taken into account as the requirements are developed.

The Academy is actively working to develop tools to help our members prepare for MACRA and its implementation. Most recently, the Academy launched DataDerm™, a robust clinical data registry developed by dermatologists for the specialty of dermatology. This registry platform includes 35 dermatology-specific and applicable measures with a focus on measuring and improving quality. DataDerm™ interfaces with electronic health records (EHRs) and will facilitate reporting of a number of Physician Quality Reporting System (PQRS) approved measures to allow dermatologists to meet current Medicare quality program requirements. Additionally, DataDerm anticipates the data needed for MACRA reports of quality, resource use and clinical practice improvement. DataDerm includes dermatology-specific non-PQRS measures that will provide a profile of care across important dermatological care issues such as skin cancer, psoriasis and biopsies. With secure data drawn from thousands of dermatologists and millions of patients, dermatologists will receive a comparative report of the quality of care they are delivering. Participating dermatologists will easily access reports that compare their performance with the national average and allow continuous monitoring of patient care through dashboards, driving a deeper analysis of their practice to proactively provide the best quality of care possible.

DataDerm™ will also prepare dermatology for the changing payment environment. It will allow the Academy to further measure development with a focus on more dermatology-specific measures and provide dermatologists with more clinically relevant and meaningful data. As a result, the specialty will be better suited to identify individual provider and specialty level measure gaps; and ultimately, DataDerm™ will provide guidance on the development of severity scales to allow for variations in patient populations.



American Academy of Dermatology Association
 Excellence in Dermatology™

1445 New York Ave., NW,
 Suite 800
 Washington, DC 20005-2134
 Main: 202.842.3656
 Fax: 202.842.4355
 Website: www.aad.org

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The Academy has also been seeking to maintain an active, strategic approach to engaging innovations in payment and delivery system reform, recognizing the importance of converging and interrelating work streams to achieve success. Dermatologists understand the importance of participating in alternative payment models (APMs), and we have begun exploring bundled care, coordinated care, and other models for select dermatologic conditions. As the Centers for Medicare and Medicaid Services (CMS) moves forward with MACRA implementation, the Academy has urged the agency to remain mindful of the importance of incorporating a broad variety of physicians into the new framework and providing the flexibility and support necessary to encourage the participation of specialists. This includes both solo and small group practitioners, whose care remains critically important to many of our patients.

A gradual, phased-in approach to the Merit-Based Incentive Payment System (MIPS) and APM provisions in MACRA, that recognizes the unique challenges of specialty care, including the practice of dermatology, will bring the new physician payment framework closer to its intended goals of rewarding quality care, ensuring patient access, and creating an efficient healthcare system. Additionally, while there are common themes between MIPS and the APM program, implementation should not conflate the pathways and erode important distinctions that might overcomplicate or confuse physician participation.

Likewise, rapid, hurried implementation of approaches to APM adoption may overlook opportunities to improve care delivery, and the Academy encourages MACRA implementation to provide on-ramps for physician participation in such models. APMs should seek to maximize the value of appropriate care, which will require a transition to APMs with specific attention to the unique context of specialists. The Academy has been engaging on such opportunities to ensure that our patients and the health system more broadly, can appropriately benefit from specialty care. Appropriate visits to dermatologists, for example, can improve accurate diagnosis and avoid unnecessary treatments and spending, a benefit from care coordination not currently captured in existing quality or resource use metrics. Central to designing APMs that closely encourage such value and enable participation in this new payment paradigm is specialty society access to all payer claims data, and to that end we encourage CMS to explore how it can encourage qualified entities (QEs) to share data more readily.

Even as the design of and move toward APMs continues, the Academy continues to support preserving the viability of fee-for-service as a payment model. The Academy has prioritized educating members about the potential risks and opportunities that APMs present due to CMS implementation of a mandated transition of health care reimbursement methods. The Academy encourage the development and implementation of APMs that incorporate efficaciousness, minimize adverse effects, promote flexibility of decision-making for providers and patients, are cost sensitive while encouraging high quality dermatologic care, are not onerous for participating physicians, and are financially feasible for patients and physicians. Through notice and comment, the Academy has encouraged CMS to ensure that specialists such as dermatologists will be able to participate in MIPS and APMs in a meaningful manner, and that the systems developed incorporate valid and meaningful quality metrics, are implemented with a reasonable timeline, and are financially viable for patients and physicians.

Additionally, the Academy is advocating for a more meaningful and less unduly burdensome Meaningful Use (MU) program. However, challenges such as barriers to interoperability and minimal flexibility of the program are a cause for concern. Many dermatology offices have had to reduce the number of patients they can see in a day by more than 30% at a time when demand for physician care is reaching an all-time high. In the Academy's annual survey of its members, it was found that 65% of respondents close to retirement age found "pressures to implement EHR" to be a significant factor in their decision to retire. For these physicians in particular, the program requirements are simply too costly and time-consuming to implement given the providers' brief period in which they would need to meet the EHR program requirements.

When Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and replaced the sustainable growth rate (SGR) with the MIPS, the intention was to move toward value-based healthcare that focuses on high-quality, efficient, and coordinated patient care. In doing so, it phases out MU.

Given this significant new direction in the regulation of EHR use, there should be a focus on ushering in a new era of rewarding the provision of high-quality patient care and redesigning how MU will function within the new MIPS framework. The Academy believes that regulations governing physicians' use of EHRs must be revised to foster technological innovation, enable interoperability, and enhance usability. Only with significant changes can the use of EHRs ultimately improve patient care and streamline physicians' workflow. The Academy believes that this work includes providing for flexibility in measuring MU, including permitting PQRS reporting to count for the clinical quality measures in MU, as well as allowing physician use of a clinical data registry to count for full MU participation. In light of the imminent regulatory changes, the Academy does not believe it would be the best use of Centers for Medicare & Medicaid Services (CMS) and physician resources to make the substantial effort that moving forward with Stage 3 of MU would require.

As physicians prepare for the changes in how they must report on and track quality and performance measures, it makes sense for CMS to take this opportunity to put a hold on new or heightened Stage 3 requirements. A longer-term, gradual approach will give providers time to catch up to the Stage 2 MU requirements and better serve the purpose of making meaningful use of EHR technology. Although physicians are adopting and using EHR programs, many are still not able to meet the MU attestation requirements. In fact, less than ten percent of physicians were able to meet MU Stage 2 requirements in 2014. If the program continues to adopt more complex standards with higher thresholds, the Academy expects to see more physicians decide the effort is not worth it and drop out of the program. Therefore, the Academy recommends that the current Stage 2 modified standards for meaningful use continue through the early implementation of MIPS. In short, we urge CMS to "pause" Stage 3 of MU.

Additionally, with the implementation of MACRA, flexibility in reporting requirements is necessary for physicians to comply with the meaningful use requirements in 2016. The Academy supports the continued use of a 90-day reporting period for physicians. More flexibility in reporting will contribute to a successful implementation of MACRA especially in 2017 when meaningful use will still be required under MIPS.

The program has also failed to focus on interoperability and has instead created new barriers to easily exchanging data and information across care settings. The Academy encourages the subcommittee to renew their focus on interoperability of EHRs by urging vendors to respond to the demands of physicians rather than the current system where vendors must meet the ill-informed check-the-box requirements of the MU program. The Academy also strongly encourages the Subcommittee to recognize the value that clinical data registries bring to healthcare, and encourage their use by supporting measures that recognize physicians utilizing an EHR to participate in a clinical data registry as satisfactorily achieving all stages of MU.

The Academy appreciates your continued leadership on this issue and look forward to working with you to ensure that physician practices are ready for MACRA implementation. The Academy would like to serve as a resource for you and your Subcommittee, as you continue to address this important issue. If you have questions, or if the Academy can provide any additional information, please contact Christine O'Connor, Associate Director, Congressional Policy at (202) 609-6330 or coconnor@aad.org



Julie Vose, MD, MBA, FASCO

**President
American Society of Clinical Oncology**

**Statement prepared for:
House Energy & Commerce Committee**

Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of Medicare Payment Reforms

March 17, 2016

The American Society of Clinical Oncology (ASCO) is pleased to submit this statement in connection with the hearing titled "*Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of Medicare Payment Reforms*" held by the House Energy and Commerce Subcommittee on Health on March 17, 2016. ASCO is thankful to the Committee for its inclusion of the physician community in shaping the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and looks forward to continued work together with you to see it successfully implemented. ASCO's membership contains nearly 40,000 physicians and other health care professionals dedicated to cancer treatment, diagnosis, and prevention. ASCO members are also dedicated to conducting research that leads to improved patient outcomes, and we are committed to ensuring that evidence-based practices for the prevention, diagnosis and treatment of cancer are available to all Americans, including Medicare beneficiaries.

ASCO thanks Chairman Pitts, Ranking Member Green and all members of the House Committee on Energy and Commerce for their attention to the critical role MACRA can play in transitioning Medicare from a volume-based to a value-based payer and the need to guarantee patient access to high-quality, high-value health care for our nation's seniors. We applaud Congress for enacting MACRA and repealing the problematic Sustainable Growth Rate (SGR); however, significant work remains ahead for the Centers for Medicare & Medicaid Services (CMS) and the provider community to implement the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APMs).

Since the enactment of MACRA, CMS has sought public comments on various aspects of the legislation, including broad comments on MACRA as part of the 2016 Medicare Physician Fee Schedule;

a comprehensive Request for Information that focused on the implementation of MIPS, APMs and physician-focused payment models; two sub-regulatory documents relating to Episode Groups for resource use under MIPS; and the draft Quality Measure Development Plan. ASCO has provided comments on each of these documents, and we will remain actively engaged throughout the MACRA implementation process.

We appreciate the monumental task that CMS has before it, but there are emerging concerns with MACRA implementation that could diminish patient access to cancer care services in the United States and result in arbitrary, unfair and counterproductive reimbursement consequences for oncology specialists. In light of these concerns, we urge Congress and CMS to take steps to ensure that oncologists and other cancer care professionals can provide meaningful access to oncology care for Medicare beneficiaries as well as avoid the pitfalls of the long-troubled SGR formula including the uncertainty of policies and reimbursement rates. We also urge the Committee to direct CMS to continue to work closely with physician specialty societies like ASCO to ensure that new reimbursement methodologies continue to promote quality, community-based patient access to care, and fairness to providers.

I. Merit-Based Incentive Payment System (MIPS)

MACRA requires CMS to implement MIPS, with payment adjustments to providers beginning in 2019 based on their performance across four performance categories: (1) resource use; (2) quality; (3) clinical practice improvement activities; and (4) meaningful use of certified EHR technology. This section discusses ASCO's specific concerns in each of these areas.

(a) Resource Use Measurement

Although we support the transition to value-based payment, we remain concerned that the MIPS methodology for measuring resource utilization could unfairly penalize oncologists that provide medically necessary care with high-costs that are outside of their control. Currently, CMS assesses resource use through the Value-Based Payment Modifier (VBM), which provides too blunt an instrument to protect and promote quality in oncology. To be successful in implementing MACRA, policymakers must learn from and avoid the mistakes made in implementing the VBM.

The treatment of cancer is both clinically complex and highly specialized, creating many factors that must be considered to accurately evaluate medical oncology resource use in a way that protects the interests of patients. There are more than 120 different types of cancer (and through advances in molecular diagnostics, this list is growing), and the most appropriate treatment option for a particular patient often involves the administration of a multi-drug regimen. In many instances, the selection of the most appropriate anticancer drug for an individual patient is based on the fact that there is a single molecular entity without any clinically equivalent substitute that provides a clear clinical advantage for the individual. In these common scenarios, the medical oncologist is left with little flexibility to reduce

drug utilization costs by selecting lower cost alternatives. It is counterproductive to assess a provider's resource use based on Part B or Part D drug expenditures that are outside of their control in this way.

Congress and CMS must not assume that variations in resource needs among patients and medical oncology providers will "average out" over time. It is common for medical oncologists to specialize in treating particular types or sub-types of cancer. There are some physicians and many oncology practices that specialize in treating the most complex—and often most costly—oncology patients. In some of those instances, there will be significant differences in resource consumption compared with other providers. We are especially concerned that if resource use measurement does not account for these clinical differences, CMS may inadvertently unfairly penalize practices and create access barriers for patients with complex and molecularly unique forms of cancer. Congress and CMS should take this situation into consideration for any process used to measure resource use in oncology and should not implement such a process until there is confidence the methodology will adequately protect quality and access to care for patients with these complex illnesses.

Given the factors described above, and because drug pricing is outside of the control of treating physicians, ASCO recommends that Congress and CMS adopt a more nuanced approach for oncology than simply comparing aggregate drug costs under Medicare Part B and Part D. Congress and CMS should exclude the use of raw drug expenditures in resource use determinations. Instead, CMS should assess drug resource use by evaluating adherence to evidence-based, value-based medical decision-making. ASCO endorses the use of high-quality clinical pathways in oncology as a mechanism to assess the provision of such care.

Appropriately designed clinical oncology pathways are detailed, evidence-based treatment protocols for delivering quality cancer care for specific patient presentations, including type and stage of disease. Clinical oncology pathways are a tool that can be used to appropriately align incentives for cancer patients and providers for resource use assessment in cancer care. Pathways are being used by an increasing number of private payers to ensure evidence-based, value-based care for cancer patients. Used in this way, clinical oncology pathways can enable oncologists, payers, and patients to provide assurances that patients are receiving clinically appropriate therapies without unnecessary costs, including drugs. Oncology pathways balance the considerations of clinical efficacy, safety, toxicities, cost, and scientific advances, including the growing personalization of therapy based on molecular diagnostics.¹ Simply put, clinical pathways help to ensure that the right patient gets the right drug at the right time. Since compliance with appropriately designed oncology pathways define optimal care, medically appropriate concordance with pathway programs that have been developed and peer-reviewed by oncologists should be considered a major quality indicator.

¹ Zon RT, Frame JN, Neuss MN, Page RD, Wollins DS, Stranne SK, Bosserman LD. American Society of Clinical Oncology policy statement on clinical pathways in oncology. *Journal of Oncology Practice*. 2016 [epub ahead of print].

In addition to drug costs, ASCO has serious concerns that CMS is failing to implement adequate risk adjustment to assess resource use in a way that fairly addresses differences in resource use among oncologists. Cancer care is incredibly complex and growing more so with each passing year, and the costs of cancer care are highly variable depending on a patient's diagnosis, cancer stage, molecular markers, geographic access to care, comorbidities and other clinical factors. In light of these complexities, it is imperative that CMS develop a risk adjustment methodology that will be specifically used to address cancer care. Traditional administrative claims data alone are insufficient to provide a desirable risk-adjustment methodology.

We urge Congress to provide oversight in this area to ensure that medical oncologists are not subject to unfair resource use measurement due to the clinical complexity of the patient populations they serve.

(b) Quality Reporting

Ensuring that quality reporting is based on a provider's day-to-day practice is essential for MIPS to become a useful tool for quality improvement. We urge Congress to work with CMS to improve quality reporting in cancer care by promoting the use of quality measures that are important to patients and have meaningful impacts on the day-to-day practice of oncology. Failure to promote clinically relevant quality reporting will continue the "check-the-box" reporting attitude of many providers toward the Physician Quality Reporting System (PQRS) used by Medicare today.

We thank Congress for its continued support of Qualified Clinical Data Registries (QCDRs) by requiring their inclusion in MIPS. For more than a decade, ASCO has offered its members the ability to participate in the Quality Oncology Practice Initiative (QOPI), which is designated as a QCDR and focuses specifically on measuring and assessing the quality of cancer care. Congress should ensure that CMS does not weaken the protections in MACRA that exempt quality measures developed for use in a QCDR from many of the measure development process requirements that other MIPS measures will be required to undergo. This exemption is of critical importance because it will give QCDRs, like QOPI, the flexibility to innovate and develop quality measures that are clinically relevant to specialty practice. One outstanding issue of concern, however, is recent clarification we have received from CMS and ONC related to provider reporting of meaningful use. As currently constructed, reporting rules do not allow providers to use the same registry for both PQRS reporting and to satisfy objective 10 of meaningful use (modified Stage 2). This policy puts providers in the position of having to use two registries for the purposes of satisfying the CMS requirements, even if information provided is different for the two reporting requirements. This is counterproductive, particularly at a time when the federal government and the provider community are trying to streamline these processes—and optimize rational use of HIT. If a provider is reporting information from a certified EHR into a registry and that registry is reporting to CMS, it should be considered that the provider is meaningfully using the EHR for purposes of meeting objective 10. Entities like ASCO, who have spent years building and refining its registry and encouraging

members to participate, will be faced with the choice of encouraging use for PQRS or declaring it a specialized registry for purposes of meaningful use. ASCO, along with many others in the provider community, raised this issue at the agency level and hopes for continued support until a resolution is reached.

Finally, it is essential that Congress continue to support the implementation of group quality reporting in QCDRs. The promotion of group reporting is critical for oncology, since individual oncologists will rarely have enough cases, within any given cancer diagnosis, to report data that is statistically valid and representative of practice patterns and overall performance.

(c) Clinical Practice Improvement Activities

The creation of the clinical practice improvement activities category offers an opportunity for CMS to encourage providers to engage in activities that can meaningfully improve the quality of care they provide. ASCO supports an attestation-based system that allows providers and groups to attest to participation in activities that meaningfully improve the quality of care they deliver to achieve the full clinical practice improvement activity score. Some examples of relevant clinical practice improvement activities that are applicable to oncology practice are participation in a QCDR, achieving ASCO's QOPI Certification and provider participation in clinical trials.

(d) Meaningful Use of Certified Electronic Health Records Technology

MACRA requires CMS to evaluate providers based on their meaningful use of certified EHR technology. We thank the Energy and Commerce Committee for its work on the House-passed *H.R. 6, the 21st Century Cures Act* which included a provision to encourage EHR interoperability. The rest of Congress should take steps to address the lack of widespread interoperability in the current health IT ecosystem and to alleviate administrative burdens of the meaningful use program prior to requiring full compliance with the meaningful use program to avoid adverse reimbursement consequences. Until widespread interoperability is achieved and the regulatory burdens associated with participation in the meaningful use program are lessened, Congress and CMS should not subject providers to penalties based on systemic problems that they had no role in creating.

II. Alternative Payment Models (APMs)

We urge Congress to help ensure that multiple oncology-specific alternative payment models (APMs) are available to oncologists in 2019. This will allow oncologists the ability to select the optimal approach to serve their patients and their community. Currently, the Center for Medicare and Medicaid Innovation (CMMI) is in the process of implementing the Oncology Care Model (OCM), which may provide one pathway for CMMI's designated 100 practices to participate in an APM. However, given

there are over 2,000 oncology practices in the United States and in consideration of the complexities of oncology care, multiple APMs focusing on oncology services are needed by 2019 so that oncologists are able to select the most appropriate payment model to provide high-quality cancer care to their patients. The availability of multiple APMs will allow for these models to be driven by physicians as this Committee intended in drafting the law rather than simply offered top-down from CMMI.

ASCO's Patient-Centered Oncology Payment (PCOP) model provides the ideal framework for an oncology-specific APM. The PCOP framework promotes patient access to the full range of services required by individuals with cancer, supporting high-quality care while reducing overall expenditures and promoting value. Participants in PCOP receive additional payments that support the medically necessary patient management and care coordination. These payments are subject to a provider's adherence to evidence-based, oncology-specific quality measures (embedded within the Quality Oncology Practice Initiative (QOPI), a well-established quality assurance and independent program that is already recognized as a QCDR by CMS), adherence to the Choosing Wisely standards for resource use, and avoidance of unnecessary hospitalizations and emergency department visits.

By supporting the full range of resources necessary for oncology providers to plan, coordinate and manage cancer treatments, the PCOP addresses the fundamental problems with the outdated codes currently used for oncology by Medicare that overemphasize face-to-face visits and drug administration services. It also provides an opportunity to produce savings while enhancing care coordination and overall quality of the patient experience.

ASCO supports Congressional action to direct CMMI to implement and test multiple APMs like PCOP, the COME HOME Project, and the Oncology Medical Home. PCOP would promote care coordination and management while removing barriers under traditional fee-for-service that stifle the delivery of high-quality, affordable oncology care. Testing the PCOP framework alongside the OCM would provide CMMI with comparative data on two separate models and would dramatically increase participation by oncologists in APMs. This would enable stakeholders to evaluate and identify the best approaches to serve the Medicare population and Medicare program over the coming decades.

III. Physician-Focused Payment Models

ASCO supports the development and implementation of physician-focused payment models as APMs. Although Congress created the Physician-Focused Payment Model Technical Advisory Committee (PTAC) when it enacted MACRA, it is still unclear how models evaluated by the PTAC could be approved and implemented for widespread use as APMs. For physicians to have a meaningful voice in the development and implementation of APMs, Congress should enact legislation that would provide a clear pathway for physician-focused payment models recommended by the PTAC to be implemented as APMs beginning in 2019.

IV. Proposed Part B Drug Payment Model

The Center for Medicare and Medicaid Innovation's (CMMI) recent proposal to implement the Part B Drug Payment Model presents a significant, independent threat to community-based oncology care and compounds our concerns with the CMS implementation of MACRA. This new demonstration not only continues to erode practice resources necessary for the care of patients with cancer, it imposes additional administrative burdens by making participation in this experiment mandatory. This requirement—in addition to the practice resources that must be devoted to participate effectively in MACRA's reformed physician payment systems—is simply not sustainable. CMMI plans to implement the first phase of its mandatory two-phase Part B Drug Payment Model in late 2016. If implemented as proposed, Medicare would no longer reimburse the majority of Medicare providers for Part B drugs under the statutory methodology of average sales price plus six percent (ASP + 6%, now ASP + 4.3% under sequestration). The model is proposed to run for five years, meaning its implementation will directly overlap with the implementation of MIPS, APMs and other MACRA-created policy initiatives. Additionally, CMS has expressed its intent to test value-based purchasing tools in Phase II of the Model, but the Agency has failed to identify or describe the tools in any meaningful detail.

We are alarmed that the Agency charged with implementing the Medicare program has published a proposal to radically alter the payment methodology for oncology drugs that is virtually devoid of any meaningful provisions to protect patient access to high-quality, evidence-based care. ASCO has long supported the need for transformative changes in the way that oncology care is covered and reimbursed; however, any effort to revise the oncology payment system must ensure that individuals with cancer maintain access to the full scope of medically necessary products and services. Any such initiatives should be tested in meaningful ways before implementation takes place on a wide scale basis, and such testing should be performed in a way that protects the interests of patients in a proactive manner. ASCO has been active in this area, including its longstanding Quality Oncology Practice Initiative, development of a Value Framework to support shared decision making, a comprehensive proposal for payment reform, and participation in the Choosing Wisely program. Oncologists have demonstrated a readiness to engage in reforms that will achieve the national triple aims of better care, better health and lower cost. It is concerning that the proposed Part B Drug Payment Model is narrowly focused on price—something not controlled by oncologists—has not been designed with stakeholder input, and is set to proceed on a mandatory, nationwide basis in the absence of meaningful pre-launch testing or evaluation.

There are too many assumptions and too few safeguards in the recent proposal to alter the payment rules for Part B drugs. The Agency fails to understand that implementing a proposal that is budget neutral in the aggregate can still run the risk of creating perverse and undesirable impacts on community-based oncology care and patient access. Before running a nationwide experiment with the vulnerable population of elderly patients with cancer, more meaningful planning and testing are necessary. Further, it is problematic to place additional strains on the oncology infrastructure at the same time that significant administrative burdens are likely to arise due to MACRA implementation.

We urge Congress to enact legislation directing CMS and CMMI to forgo implementation of the ill-conceived Part B Drug Payment Model.

* * * * *

Thank you for your leadership on passage and continued oversight to ensure successful implementation of MACRA. We look forward to working with you and your staff's to ensure that Medicare beneficiaries have access to oncology services moving forward. Please contact Amanda Schwartz at Amanda.Schwartz@asco.org with any questions.



Statement of the College of Healthcare Information Management Executives

House Committee on Energy and Commerce
Subcommittee on Health

Hearing on "Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of Medicare Payment Reforms"
2322 Rayburn

March 17, 2016

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to submit a statement for the record for the March 17, 2016, hearing entitled, "Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of Medicare Payment Reforms." We appreciate the committee's leadership and continued interest in the transformation of the nation's healthcare system to better meet patient needs in the 21st Century.

CHIME is an executive organization serving more than 1,800 chief information officers (CIOs) and other senior health information technology leaders at hospitals and clinics across the nation. CHIME members are responsible for the selection and implementation of clinical and business technology systems that are facilitating healthcare transformation. Our organization is a strong proponent of health IT and its ability to enable improvements in health care quality, increase affordability, and improve healthcare outcomes.

Enabling a Digital Infrastructure to Foster Delivery System Reform

Since enactment of the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), the healthcare industry has made a significant shift in the way technology is used to treat and engage with patients. The prolific adoption of electronic health records (EHRs) and other health IT resources by clinicians and patients will pay dividends as the nation's physicians transition to value-based care under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA.)

The shift from a fee-for-service model is not to be understated; technical challenges and opportunities associated with generating reliable performance data to determine reimbursement will be a challenge with existing technology. A robust digital health infrastructure — built around highly functional and user-friendly EHRs — is key for physicians and hospitals to be successful in new payment models, including the pathways created under MACRA. To ensure providers have the technology necessary to enable a value-based, outcomes-driven care environment, the committee should consider actions to:

1. Create parity for both eligible providers (EPs) and eligible hospitals (EHs) by removing the existing pass/fail construct and add additional flexibility under the Meaningful Use program.

College of Healthcare Information Management Executives (CHIME)
710 Avis Drive, Suite 200 | Ann Arbor, MI 48108 | 734.665.0000 | www.chimecentral.org

2. Reduce the burden of quality measure reporting for providers by streamlining reporting redundancies and refrain from requiring data collection and submission on measures that do not directly advance patient care.
3. Promote standards-based interoperability.

Parity for Physicians and Hospitals in the Meaningful Use Program

As the Centers for Medicare and Medicaid Services (CMS) develops a regulatory framework for MACRA, officials have alluded to forthcoming flexibility for physicians in the Meaningful Use program, including a change to the pass/fail or “all-or-nothing” construct. However, the agency has stated that the same authority does not enable similar changes for hospitals. The pass/fail approach does more harm than good; it jeopardizes the hard work and investments that well-intended providers have made to meet the program’s requirements and risks them incurring a financial penalty, even after making a good faith effort to be successful in the program.

The agency’s consideration of removing the pass/fail construct for EPs is welcome, however, leaving it in place for hospitals will introduce a level of complexity that will be very difficult for providers and CMS to manage. This is especially important as payment models evolve to necessitate greater coordination between hospitals and physician offices – delivery system reforms encourage a longitudinal approach to patient care, rather than episode by episode. Further, having a different set of program expectations for different providers could jeopardize attempts to by Accountable Care Organizations (ACO) or bundled payment models to better coordinate care. It’s imperative that CMS streamline the Meaningful Use program for hospitals and physicians and remove the pass/fail construct for all providers.

Improving Quality Measurement

The future of value-based reimbursement is contingent on the ability to improve performance. Congress should prioritize a unified strategy for measuring, capturing and communicating quality in healthcare. Efforts have been underway since before passage of HITECH to devise quality indicators that can be electronically captured in clinical workflow, yet organizations still must deploy sizable staffs for manual abstracting as electronically generated measures are inaccurate and unreliable. A study published in *Health Affairs*¹ this month showed medical practices in just four specialties spend an estimated \$15.4 billion each year reporting whether they are meeting their quality targets, which on average costs them \$40,069 per physician or 785 manpower hours.

Currently, providers are required to report clinical quality measures (CQMs) to several public and private entities. Individual healthcare delivery organizations submit more than 20 reports across federal, state and private sector programs for various CQMs each month. Hours of work and expertise are required to comply with these reporting demands and such burdens are exacerbated by a lack of technical harmonization. In other words, even when the same CQMs are used among different programs, they tend to require different technical specifications or values to be reported. The goal should be to eliminate duplicative quality measures and reporting requirements which in turn would reduce healthcare costs and allow clinicians to focus more attention on patient care.

¹ Casalino, Lawrence P., David Gans, Rachel Weber, Meagan Cea, Amber Tuchovsky, Tara F. Bishop, Yesenia Miranda, Brittany A. Frankel, Kristina B. Ziehler, Meghan M. Wong, and Todd B. Evenson. "US Physician Practices Spend More Than \$15.4 Billion Annually To Report Quality Measures." *Health Affairs* 401-406 35.3 (2016). <http://healthaffairs.org/>. Mar. 2016. Web. 16 Mar. 2016.

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The successful administration of MACRA programs will hinge on providers' and CMS' ability to accurately capture and meaningfully measure the quality of care delivered to the nation's patients. Efforts to reduce provider burden by streamlining reporting redundancies must be a priority and requiring data collection and submission on measures that do not advance patient care must cease. Access to real-time, actionable data will be critical for success in the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs), thus we must ensure that policies are supported to enhance the capabilities of EHRs in this area and free vendors to pursue innovative solutions that best meet provider and patient needs.

Promoting Interoperability

Improving quality of care and lowering costs will be contingent on the free flow of patient data across care settings, a must for delivery system reform. Unfortunately, today patients and care providers are missing opportunities to improve people's health and welfare when information about care or health status is not easily available. Notably, robust information exchange and nationwide interoperability can flourish only once we can confidently identify a patient across providers, locations and vendors.

While a focus on standards may seem overly simplistic, a more defined technical infrastructure is needed to catalyze innovations in digital health. We recognize the work underway at the Office of the National Coordinator for Health IT (ONC) to tackle these challenges, nonetheless barriers remain and maintaining the status quo will stifle future progress. The federal government should continue to drive standards identification and adoption in the following nine categories: patient identification, resource locators (e.g. provider directories), terminologies, detailed clinical models, clinical data query language based on the models and terminology, security (standard roles and standards for naming types of protected data), application program interfaces (APIs), transport protocols and expressing clinical decision support algorithms. It's imperative that ONC continue to leverage relationships with the private sector to capitalize on the progress made to date across the industry.

Insofar as certification is the method HHS is using to achieve adherence to technical standards and specifications, the form and function of certification needs to adapt. ONC's Certification Program must be considered as a primary vehicle for enhancing interoperability and care coordination, thus acknowledging that the voluntary certification as the only current means to enforce technology developers' compliance to federal law.

A great deal of innovation is underway to develop population health tools and other new technologies that will be critical for advancing provider success in APMs. CMS must avoid a heavy-handed approach to determining what technologies providers must use. Further, the Department of Health and Human Services (HHS), more specifically CMS in coordination with ONC, should take an approach that allows innovation to continue to flourish rather than prematurely try to certify these innovative technologies.

As the committee monitors the implementation and administration of MACRA policies, we urge Members to ensure providers have access to technology necessary to facilitate their success in new payment models and drive care improvements for patients while ensuring CMS pursues reasonable policies that will reduce provider burden, facilitate greater care coordination, and direct the maximum amount of attention on the care delivered to patients.



STATEMENT FOR THE RECORD

House Energy and Commerce Committee
Subcommittee on Health:

*Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of
Medicare Payment Reforms*

March 17, 2016

Dear Chairman Pitts and Ranking Member Green:

The Healthcare Leadership Council (HLC) appreciates the opportunity to submit a statement for the record regarding the hearing entitled, "Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of Medicare Payment Reforms." We applaud the subcommittee for focusing on the implementation of these extremely important reforms to the Medicare program.

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 health 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, biotech firms, health product distributors, pharmacies, post acute care providers, and information technology companies – advocate measures to increase the quality and efficiency of healthcare through a patient-centered approach (attached is a list of our members).

In 2015, as part of the National Dialogue for Healthcare Innovation (NDHI) initiative, HLC convened leaders of healthcare organizations, patient advocacy organizations, federal government officials, and academic health policy experts to build consensus on a broad spectrum of steps necessary to strengthen health system value and enable health innovation to have a greater positive impact on the entirety of the healthcare continuum.

NDHI participants came to the conclusion that healthcare in the U.S. can be significantly improved by focusing on improvements that are readily achievable via legislation, regulation, or voluntary actions by various health system players. Positive health system transformation does not require a wholesale remaking of health delivery structures, but rather the enabling and acceleration of patient-centered innovation.

Attached is our final report detailing the findings of this seminal group of leaders. Many of these recommendations are directly relevant to ensuring the success of MACRA and also to achieving the goals set by the Department of Health and Human Services of tying 50% of fee-for-service Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2018.

As our healthcare system shifts from fee-for-service to value-based models evaluated through outcomes, NDHI finds that some laws and regulations that were once important to the healthcare system may no longer be applicable or may inhibit transformation efforts in unintended ways. Once payment and outcomes are aligned, there is less need for government regulation on process, since consumers and healthcare organizations share healthcare goals and responsibility for achieving them. Laws designed to prevent anticompetitive behavior, for example, now sometimes hinder the coordination needed for the best patient care.

NDHI participants have focused on two of the primary fraud and abuse laws – the Federal Anti-Kickback Statute and Physician Self-Referral (Stark) Law – and prioritized options that should be pursued to better support innovative payment and delivery reforms for organizations participating in alternative payment models. These options include

- Requiring HHS Services Secretary to review and assess the Federal Anti-Kickback Statute and Stark Law as well as the Civil Monetary Penalties (CMP) Law (expansion of current MACRA requirements) in the context of health system transformation, specifically addressing whether the laws create unnecessary barriers to new integrated care models and whether these laws are effective in limiting fraudulent behavior. Changes identified through this assessment may yield opportunities to amend fraud and abuse laws to foster healthcare arrangements that promote increased quality and lower costs.
- Granting OIG and CMS broader flexibility and discretion to develop exceptions and safe harbors to the Federal Anti-Kickback Statute and the Stark Law

consistent with current health policy objectives (e.g., increased efficiency and quality, decreased cost).

Please find more analysis and further options to address the current federal fraud and abuse legal framework – to make it more compatible with value-focused, integration-oriented health system transformation – in the attached report.

On behalf of HLC, I applaud you for your bipartisan work to support alternative payment reforms. We are committed to educating members of Congress and the public about the need to align incentives and shift to value-based care models – provided that these models allow the flexibility for participants to innovate in their quest to provide the highest quality, highest value care.

We stand ready to assist and support your efforts.

Sincerely,



Mary R. Grealy
President

Attachments

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Minority (202) 725-2937
Minority (202) 725-3641

April 15, 2016

Dr. Patrick Conway
Deputy Administrator for Innovation
And Quality
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Conway:

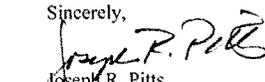
Thank you for appearing before the Subcommittee on Health on March 17, 2016, to testify at the hearing entitled "Medicare Access and CHIP Reauthorization Act of 2015: Examining Implementation of Medicare Payment Reforms."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on April 29, 2016. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Patrick Conway's Hearing
"MACRA"
Before
E&C Health Subcommittee

March 17, 2016

Attachment — Additional Questions for the Record

The Honorable Joseph R. Pitts

1. Can you detail the steps CMS has already taken to engage the stakeholder community notably physicians and providers, as well as their specialty associations, in the development of the MACRA rule? Specifically, MACRA explicitly requires CMS to engage directly with physician stakeholders to implement various aspects of MACRA, can you update us on this communication to date and what will be forthcoming?

Answer: CMS is committed to engaging with stakeholders in implementing this important legislation. In CMS's calendar year 2016 Medicare physician fee schedule proposed rule, we solicited comments regarding implementation of certain aspects of the Merit-based Incentive Payment System (MIPS) and broadly sought comments on the topics in MACRA, including the framework for providing the incentive payments associated with APM participation. On October 1, 2015, we released a Request for Information (RFI), asking for comments from the stakeholder community on many topics related to MIPS, alternative payment models (APMs), quality measurement, and meaningful use of certified electronic health records (EHRs). Further, in December 2015, CMS, in conjunction with the Office of the National Coordinator for Health Information Technology, issued an RFI to assess policy options that could improve the effectiveness of the certification of health information technology and specifically the certification and testing of EHR products used for the reporting of quality measures. We know physicians and other clinicians have a lot of demands on their time, and we are grateful for the robust response from the stakeholder community to these requests for feedback. We are currently in the process of reviewing and incorporating the feedback we received, and we anticipate releasing a proposed MACRA implementation rule, including a 60-day comment period, this Spring. We look forward to continued engagement from Congress and the health care community.

In addition, through MACRA, Congress established a new independent advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC meets on a periodic basis to review physician-focused payment models submitted by individuals and stakeholder entities and prepare comments and recommendations on proposals that are received, explaining whether models meet criteria for physician-focused payment models. The 11 members of the PTAC, who were appointed by the Comptroller General, are experts in physician-focused payment models and related delivery of care, including researchers, practicing physicians, and other stakeholders. The first PTAC meeting was held on February 1, 2016, and presentations from the meeting are available online. CMS looks forward to receiving recommendations for new physician-focused payment models. We will need stakeholder

engagement with the PTAC, including physicians and other clinicians, to suggest well designed, robust models that could meet the statutory criteria to be an eligible APM.

2. **The final rule for MACRA implementation for performance year 2017 is expected to be released later this year. Some have worried that a few months is not enough time for practices to transition to MIPS. How does CMS plan to accommodate practices during this transition period?**
 - **The legislation provides CMS with instruction and funding for physician outreach in this transition and information on how to report - what type of education and support will be provided to practices?**
 - **Will specific efforts be undertaken for small or rural practices?**
 - **Can you outline these efforts and what we can tell our providers to expect as far as resources and engagement from CMS?**

Answer: CMS knows that physicians and other clinicians may need assistance in transition to the Merit-based Incentive Payment System (MIPS) and we want to make sure that they have the tools they need to succeed in a redesigned system. In addition, Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as regional extension centers and regional health collaboratives to offer guidance and assistance to physicians and other clinicians. The technical assistance is to focus on the performance categories under MIPS, helping to make it as seamless as possible for these clinicians and practices to comply with MIPS requirements and helping interested practices transition to implementation of and participation in an alternative payment model. We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance.

In addition to the MACRA funding, in September 2015, CMS awarded \$685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and spend dollars more wisely. The Transforming Clinical Practice Initiative is one of the largest federal investments designed to support physicians and other clinicians in all 50 states through collaborative and peer-based learning networks.

3. **When does CMS plan to notify physicians whether they are qualified APM participants for the 2019 payment year?**
4. **Will CMS administer the 2019 APM payment update in a way that allows physicians who are qualified APM participants to forego participation in MIPS in 2017 or do you think all physicians will need to assume they must meet the 2017 MIPS reporting requirements because they will not know whether they meet the 2019 APM payment update requirements?**

5. Would you be willing to speculate as to how many physicians will qualify for the APM bonus payment in the initial years of its availability? If the number is low, why?

Answer 3-5: MACRA established a particular definition of alternative payment models (APMs) and established what qualifies as an “eligible APM,” for purposes of exempting eligible professionals from the Merit-based Incentive Payment System (MIPS) and allowing eligible professionals to receive a special incentive payment as a qualifying APM participant. While creating this new category of eligible APMs provides for promising incentives for a growing number of eligible professionals in the future, we expect the initial years to be ones of development as we apply lessons learned and continue to refine the program. The statute creates a high bar for eligible APMs, and many currently existing APMs are not likely to meet all these requirements, but some will. We will continuously search for opportunities to expand the range of options for participation in eligible APMs within the contours of the statute.

In keeping with the statute, it is our intent to align the MIPS and APM components of the new payment system to the extent feasible, thus allowing maximum flexibility for physicians and other clinicians who are not yet ready for eligible APMs to participate in MIPS and then migrate to eligible APMs when they are ready. As we move forward with MACRA implementation, we will continue to gather and incorporate feedback from stakeholders as we promote additional physician-focused APMs. We look forward to addressing important issues around eligible APM participation through our proposed rule later this Spring, and we will keep physicians and other clinicians updated throughout the rulemaking process.

6. Building off the efforts to align quality measures, has CMS done any modeling if commercial payers are engaged in value based products and payment arrangements?

- **Would CMS be open to counting risk based commercial models to a providers APM threshold?**
- **Do you envision that Medicare Advantage would or could count towards a providers APM threshold?**

Answer: Beginning in 2019, under MACRA, as an alternative to participation in the Merit-based Incentive Payment System, clinicians (“eligible professionals”) can receive a 5 percent incentive payment for participation above a specified threshold amount in certain types of Alternative Payment Models (APMs). For the first two years, incentive payments are based on participation in Medicare APMs. However, starting in 2021, under the law clinicians can receive the incentive payment through a “combination all-payer and Medicare payment threshold option.” We believe this is an important option that will reward commercial plans’ and clinicians’ value-based payment arrangements and further encourage clinicians and commercial plans to develop new APMs. We plan to provide further specifications on our proposal for the combination all-payer and Medicare payment threshold option in the forthcoming proposed rule implementing the payment provisions in MACRA. In addition, MACRA requires that CMS submit to Congress a report on exploring the feasibility of the use of APMs in Medicare Advantage.

- 7. The Merit Based Incentive Program (MIPS) attempted to respond to criticisms that quality measures were being applied to physicians in a one size fits all manner with practices being judged on measures complexly irrelevant or inapplicable to their practice. What is CMS doing to further the Congressional intent of the statute and can you describe how MACRA provides flexibility for providers to be judged on quality measures relevant to their unique practice or specialty?**

Answer: MACRA combines three existing quality programs– the Physician Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare Electronic Health Record Incentive Program – into one, aligned new program, the Merit-based Incentive Payment System (MIPS) beginning with payments in 2019. Physicians and other clinicians will be evaluated under MIPS based on a single composite performance score, which will factor in performance on four weighted categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified electronic health record (EHR) technology. We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician’s individual practice and patient population.

- 8. MACRA made important reforms to how quality measures can be more quickly incorporated into Medicare by allowing the Secretary to work with provider and physician groups on validating and adopting quality measures that may not yet be endorsed. Can you speak to this new flexibility and how CMS is approaching the ability for this enhanced collaborative relationship with providers on quality measurement?**

Answer: Our goal at CMS is to ensure clinicians have the ability to use clinical quality measures that are evidence-based, right for their practice and their patients, and align with quality improvement goals. In implementing MACRA, CMS will use the rulemaking process to establish an annual list of MIPS quality measures. This list will include, as applicable, quality measures from existing CMS quality programs: the Physician Quality Reporting System, the Value-Modifier, and the Medicare EHR Incentive Program. In addition, CMS will use the annual “Call for Measures”, established by the law, to request that eligible professional organizations and other relevant stakeholders identify and submit quality measures to be considered for selection in the annual list of quality measures and to identify and submit updates to the measures on such list. We believe the process to gather input from eligible professional organizations is an important way to bring new measures into the program and provide measure options for clinicians.

CMS is also working to partner with third-party organizations to collect and report quality measurement data for purposes of MIPS. For example, MACRA encourages the use of certified electronic health record (EHR) technologies and Qualified Clinical Data Registries for reporting quality measures. Measures developed from electronic data sources such as EHRs, as well as from QCDRs, draw from a rich set of clinical data and can reduce data collection and reporting burden while supporting more timely performance feedback to clinicians than is possible through traditional claims-based measures.

9. **In order to improve patient outcomes and enhance quality of care, the Merit-Based Incentive Payment System (MIPS) incorporates patient engagement features. The RFI issued in October regarding Section 101 of MACRA did not request comment on patient engagement and self-management assessment. There is a direct connection between patients taking an active role in managing their health conditions and improved outcomes especially when providers coach patients in a customized manner to encourage better self-management. National and international use of patient self-management assessment measures that are validated and extensively peer-reviewed and paired with interval level self-management intervention techniques have repeatedly resulted in enhanced health outcomes and reduction in unnecessary utilization. As CMS develops MIPS, will it direct providers to rely on an empirically validated, interval level, patient self-management assessment tool to determine a beneficiary's self-management capabilities?**

Answer: CMS is committed to engaging with all stakeholders, including patients and caregivers, in implementing this important legislation. In CMS's calendar year 2016 Medicare physician fee schedule proposed rule, we solicited comments regarding implementation of certain aspects of the Merit-based Incentive Payment System (MIPS) and broadly sought comments from the public on the topics in MACRA. Further, in December 2015, CMS, in conjunction with the Office of the National Coordinator for Health Information Technology, issued an RFI to assess policy options that could improve the effectiveness of the certification of health information technology and specifically the certification and testing of EHR products used for the reporting of quality measures. We are currently in the process of reviewing and incorporating the feedback we received, and we anticipate releasing a proposed rule, including a 60-day comment period, this Spring.

In addition, to understand and measure patient and caregiver experience of care, CMS implements patient experience surveys across multiple programs and settings of care. These surveys ask patients (or in some cases, their families or caregivers) about their experiences with healthcare providers and address topics for which patients are the only or best source of information, such as whether the person was treated respectfully. CMS will continue to develop new patient experience surveys to ensure that these important measures of quality encompass all care settings and providers (e.g., specialists). As noted in our draft Measure Development Plan, CMS will also refine existing patient experience surveys based on stakeholder feedback to incorporate additional topics that are important to patients and families/caregivers (e.g., knowledge, skill, and confidence for self-management and whether the provider acted in accordance with the person's preferences; participation of family members in care discussions or electronic communications; accurate documentation of family members who are authorized decision-makers). CMS will explore incorporating an assessment of cultural competency and perspectives of minority and vulnerable populations (e.g., individuals with limited English proficiency, low health literacy, mobility impairments or other disabilities). In addition, CMS will consider measurements for the physician practice of using tools to assist patients in assessing their need for support for self-management as we move forward in drafting our proposed rule. CMS will balance the effort to obtain important information with the need to minimize burden to patients and clinicians in implementing and responding to the surveys. As we move forward under MACRA, we will be sharing details and inviting comment as part of the rulemaking process this Spring.

10. One of the major challenges facing measure developers is getting quality measures approved by a consensus based organization. MACRA created new flexibilities to encourage measure development and create a direct line for those society developed measures to CMS. Yet, CMS' proposal in their draft Quality Measure Development Plan would require measures that are not NQF-endorsed to align with NQF requirements for its consensus review process. This action seems to undercut the flexibility provided under MACRA. Can you speak to this?

Answer: For measures that are not endorsed by a consensus-based entity, MACRA requires that the measures have a focus that is evidence-based. The law, however, does not define evidence-based or specify how to evaluate the evidence. The use of a consistent set of criteria for evaluating evidence will ensure that measures developed for use in CMS programs are rooted in strong evidence.

As discussed in the draft Measure Development Plan, CMS plans to use the rating criteria established by NQF to evaluate the quality, quantity, and consistency of the evidence for the development of quality measures included in this plan. For measures that are not consensus-endorsed, CMS will ensure that each measure is evidence-based and in alignment with NQF requirements for the consensus review process. This helps to ensure that measures are evidence-based, reliable, and valid. CMS also plans to require that measure developers submit a well-crafted business case for a measure concept that includes a thorough review of evidence.

We believe that it is important to streamline the process for measure development and are working to do this. At the same time, an evidence-based focus is important for evaluating new measures. We received many comments from stakeholders on the Measure Development Plan, and we will take them into consideration as we develop the final plan.

11. Section 102 of MACRA authorizes \$75 million to be used over five years, beginning with fiscal year 2015, to expand and enhance existing measures and to develop new measures to fill performance gaps. Has CMS allocated any of this funding, and if not, why not?

Answer: MACRA provides CMS with \$15 million annually from FY 2015 to FY 2019 for development of quality measures to support the Merit-based Incentive Payment System and Alternative Payment Models. To meet the requirements of the statute, CMS posted a draft Measure Development Plan on its website on December 18, 2015, with a public comment period through March 1, 2016. The final plan will be posted in May, followed by updates thereafter as appropriate. This plan will be used to guide the priority areas for measure development.

CMS recognizes the importance of measure development as we work to implement the provisions of MACRA. The process of preparing a measurement proposal concept, seeking bids, and assessing competitive bids will soon be underway. CMS has actively engaged with specialty societies to learn about their interests in the funding and is synthesizing the results of these engagement sessions in order to allocate funding in a way that meets the needs of these organizations and adheres to statutory requirements.

12. What, if any, analysis has CMS conducted as to whether or not existing quality programs (including both value based payment arrangements as well as Physician Quality Reporting System PQRS) have had a meaningful effect on quality improvement?

- Can you speak to any savings these efforts have generated in addition to quality improvement?
- Do you have any information in this regard broken down by medical specialty?
- If so are there certain specialties that are notable in their work to meaningfully improve quality?

Answer: In January 2015, the Administration announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients. Earlier this year, the Administration announced that it has already reached its first goal ahead of schedule: an estimated 30 percent of Medicare payments are tied to alternative payment models (APMs), and millions of Medicare patients are benefitting from better coordinated and improved quality of care. Ultimately, this shift towards quality and value will help patients receive, and doctors and other clinicians provide, the best care possible. We are already seeing national trends in health care improvements that are promising and likely a combined result of our efforts:

- There has been a 17 percent reduction from 2010 to 2014 in the number of hospital acquired conditions, such as pressure ulcers, infections, and avoidable traumas, representing over 87,000 lives saved and \$20 billion in cost savings.¹
- Between April 2010 and May 2015, an estimated 565,000 readmissions were prevented across all conditions, compared to the readmission rate in the year prior to the passage of the Affordable Care Act (April 2009 to March 2010). That's 565,000 times that a patient didn't have to experience an extra hospital stay.²
- Accountable Care Organizations (ACOs) continue to show promising results. Last fall, CMS released the 2014 quality and financial performance results for Medicare Shared Savings Program ACOs who started the program in 2012, 2013, and 2014. Ninety-two Shared Savings Program ACOs held spending \$806 million below their targets and earned performance payments of more than \$341 million as their share of program savings. The results also showed that Shared Savings Program ACOs that reported on quality in both 2013 and 2014 improved on 27 of the 33 quality measures, including patients' ratings of clinicians' communication, beneficiaries' rating of their doctors, screening for tobacco use and cessation, screening for high blood pressure, and Electronic Health Record use. Shared Savings Program ACOs also outperformed group practices reporting quality on 18 out of 22 measures.
- Pioneer ACOs are early adopters of coordinated care and tend to be more experienced, have an established care coordination infrastructure, and assume greater performance-based financial risk. These ACOs showed continued strong performance and improvement across financial, quality of care, and patient experience measures. During 2014, Pioneer ACOs generated total model savings of \$120 million and improved the

¹ <http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2014.html>

² <http://www.hhs.gov/blog/2016/02/24/reducing-avoidable-hospital-readmissions.html>

average performance score for patient and caregiver experience in 5 out of 7 measures compared to Performance Year 2, suggesting that Medicare beneficiaries who obtain care from a provider participating in a Pioneer ACO continue to report a positive experience.

Overall, in performance year 2014, Medicare ACOs in the Pioneer ACO Model and the Shared Savings Program have resulted in combined total net savings of \$411 million. Savings in the Pioneer ACO Model coupled with improved quality of care led the independent CMS actuary to certify that, as tested in the first two years, the model was eligible for expansion in accordance with the requirements of section 1115A.

Although savings broken out by specialty are not available, as described above, we have seen gains through a broad spectrum of models and value-driven initiatives. We expect these gains will continue to increase over the course of the year, including among bundled payment models within specialty care areas, with the start of the Comprehensive Care for Joint Replacement model and the Oncology Care Model. Ultimately, this shift towards quality and value will help patients receive, and doctors and other clinicians provide, the best care possible.

Every year, CMS issues a Physician Quality Reporting System (PQRS) Experience Report, which has provided data and trends on participation in PQRS since the beginning of the program. The participation rates have increased steadily since it first began in 2007, and a wide array of specialists participate. More specialty-specific quality measures are added to the program each year, and will continue to be added in future years under the Merit-based Incentive Payment System (MIPS), giving specialists the opportunity to report measures that are meaningful to them and pertain to their practice of medicine. We believe that the PQRS program has strengthened the focus on quality and provided clinicians with information they can use to improve.

13. As you know, failure to appropriately apply risk adjustment can inappropriately penalize providers who care for high risk or complicated populations which is why MACRA allowed for a professional to see their MIPS score adjusted – what are your thoughts on the successful implementation of risk adjustment given CMS’s experience with other risk adjustment methodologies?

Answer: Equitably evaluating provider performance for outcome measures requires careful consideration and evaluation of associated patient risk factors. Specific to risk adjustment, CMS is participating in a National Quality Forum (NQF) pilot project to evaluate incorporation of sociodemographic factors into risk-adjustment models. In addition, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research on this issue, as directed by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. CMS has been collaborating closely with ASPE on the implementation and analyses of this research, and the first of two reports to Congress are expected to be issued by October 2016.

Furthermore, CMS is promoting collaboration among measure developers in the development of risk-adjustment methodologies. The development and expansion of the National Testing Collaborative (NTC) should also increase the availability of data to identify and test data elements for incorporation into risk-adjustment models. The NTC is an HHS initiative sponsored jointly by CMS and the Office of the National Coordinator. The goal of the collaborative is to

expand and improve measure development and testing by incorporating earlier and more frequent engagement across stakeholders through all phases of measure development.

14. We have heard from physicians and physician practices that were previously successful with PQRS but who have been marked as PQRS failures in 2016 and are receiving a penalty. Many are reporting they do not know why. Can you explain why there appears to be such a high failure rate with PQRS in 2016?

- o **Have you looked to see how many previously successful PQRS reporters were judged to have failed this year?**

Answer: The payment adjustment of -2.0 percent under PQRS for 2016 is based on reporting quality measures during a 2014 performance period. The 2014 PQRS Experience Report will be issued in the next few months, which will provide data on the number of professionals who successfully participated in the program in 2014, as well as those who are subject to the -2.0 percent payment adjustment. For those professionals who did not meet the reporting requirements in 2014, one of the reasons may be that these requirements were more rigorous in 2014 as compared to those in 2013, which was the first performance period for application of the negative payment adjustment. In this first year, the criteria were established to give professionals new to the program the opportunity to learn how to report under PQRS, and professionals were only required to report one measure. In 2014, the requirements increased to require successful reporting of three quality measures.

We continue to examine and redesign the submission process and mechanisms for reporting to reduce burden and make these processes user-centered and responsive. We are also continuing to provide targeted outreach, education materials and national trainings with the goal of allowing all professionals to be successful participants. We will continue to do this and strengthen our efforts as we move forward with the last two years of the PQRS program and as we transition to MIPS.

15. How do you envision providers will be able to document, report or attest to their participation in or completion of clinical practice improvement activities?

Answer: CMS is committed to finding methods for providers to document the fulfillment of their efforts in each of the categories that will be evaluated under the Merit-based Incentive Payment System (MIPS), including clinical practice improvement activities that will be as efficient as possible and keep provider burden to a minimum. As we move forward under MACRA, we will be sharing details and inviting comment as part of the rulemaking process this Spring.

16. What process will CMS create for physician specialty societies to create and/or propose Clinical Practice Improvement Activities? Do you intend to require participation in certain activities?

Answer: The clinical practice improvement activities performance category of the Merit-based Incentive Payment System (MIPS) is required to include at least the following subcategories (to which the Secretary may add):

1. Expanded practice access
2. Population management
3. Care coordination
4. Beneficiary engagement
5. Patient safety and practice assessment
6. Participation in an Advanced alternative payment model

We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population.

We know that physicians and other clinicians may need assistance in transition to the Merit-based Incentive Payment System (MIPS) and we want to make sure that they have the tools they need to succeed in a redesigned system. In addition, Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as regional extension centers and regional health collaboratives to offer guidance and assistance to physicians and other clinicians. The technical assistance is to focus on the performance categories under MIPS, including the meaningful use of certified electronic health record (EHR) technology category, helping to make it as seamless as possible for these clinicians and practices to comply with MIPS requirements and helping interested practices transition to implementation of and participation in an alternative payment model. We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance.

In addition to the MACRA funding, in September 2015, CMS awarded \$685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and spend dollars more wisely. The Transforming Clinical Practice Initiative is one of the largest federal investments designed to support physicians and other clinicians in all 50 states through collaborative and peer-based learning networks. As with all major implementations, CMS continually assesses resource needs.

As we move forward under MACRA, we will be sharing details and inviting comment as part of the rulemaking process this Spring.

17. Does the agency intend to evaluate the impact of the value modifier program on small practices and solo practitioners in time to inform how resource use will be applied to MIPS?

Answer: The Value Modifier (VM) will apply to physicians in small practices (less than 10 eligible professionals) and physician solo practitioners for the first time in 2017. Since this is the first year that these professionals will be subject to "quality tiering" under the Value Modifier, they will be held harmless during this year from any downward adjustments due to poor

performance on quality and cost measures. The performance period for the 2017 VM payment adjustment year is 2015. As the program is phased in for these small groups and solo practitioners, we continue to consider performance measurement and the lessons learned to inform future policy development under MIPS as well as refinements to the VM in its remaining years. For example, last year in the 2016 Physician Fee Schedule final rule, based on an updated reliability analysis, CMS made a revision and finalized a policy not to apply the 30-day all cause readmission measure to solo practitioners and small practices with less than 10 eligible professionals under the VM. In addition, CMS plans to issue an annual Value-based Payment Modifier Program Experience report. The first one was issued in June 2015, which analyzed the results for the first year of the program. We expect this report to examine characteristics of group practices and their corresponding performance under the Value Modifier.

- 18. MACRA allows any performance category that a physician, group or specialty could not realistically succeed in to be reweighted. Will CMS consider re-weighting the resource use category until there is more consensus on the best means by which to evaluate resource use? Does CMS intend to have issues surrounding resource use application settled by implementation? How does CMS anticipate transitioning from the measures under the value based modifier to the use of episode groups?**
- 19. As outlined in the law, the HHS Secretary can incorporate Part D drug spending as part of the resource use component of MIPS, to the extent it is feasible. The current resource use metrics only account for spending on physician administered drugs paid under Part B. Some physicians sometimes have the option to prescribe either a Part B or a Part D drug for a given condition. Since the decision usually comes down to patient choice, one provider may treat a patient with a Part B drug while another rheumatologist treating a patient with the same indications and risk factors could just as easily choose a Part D drug. Under CMS' current resource use methodology, the patient who opted for the Part B drug would appear more costly than the patient who opted for the Part D drug, which would translate into higher resource use and potential financial penalties for the treating physician. Can you elaborate on this situation and how patient choice and the practice of medicine will not be impacted by this provision? Will the proposed rule speak to how CMS is planning to address resource use when it comes to physician-administered and self-administered medications? Has CMS come to a conclusion on how it can incorporate Part D drugs in resource use measurement under the new MACRA programs?**

Answer 18 & 19: CMS issued a Request for Information that invites feedback on many questions related to resource use, including how Part D drug costs should be incorporated into MIPS. The feedback we received will help to inform our proposed rule, which will address many critical aspects of MACRA implementation. As we move forward, we will be sharing details and inviting comment as part of the rulemaking process.

- 20. Can you update us on CMS' and more broadly the Department of Health and Human Services efforts to implement the December 18, 2018 deadline for EHR interoperability imposed by MACRA?**

Answer: The Office of the National Coordinator for Health Information Technology recently released “Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap,” which describes the milestones, calls to action, and commitments to be achieved by 2017 in support of this goal.³

- 21. When Congress enacted the "Protecting Access to Medicare Act of 2014" (P.L. 113-93), which I am proud to say I sponsored, one of our goals was to promote evidence-based care by utilizing appropriate use criteria for certain advanced diagnostic imaging services. In so doing, we wanted to ensure these provisions did not have an unintended consequence of delaying care for patients who sought medical attention in an emergency department until after it was determined that they did not have an emergency medical condition (as defined in section 1867(e)(1)). This exception not only covers individuals with an identified emergency medical condition, but also the applicable imaging service ordered to determine whether or not the individual has an emergency medical condition.**
- 22. What is your agency doing to make sure that the rules being promulgated in regard to this section of P.L. 113-93 are compatible with our intent? Can you assure me that the appropriate use criteria exception will cover the medical screening exam as well as patients with an emergency medical condition?**

Answer 21 & 22: We look forward to addressing these issues in upcoming rulemaking.

Section 218(b) of the PAMA directed CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. We believe the goal of this statutory AUC program is to promote the evidence-based use of advanced diagnostic imaging to improve quality of care and reduce inappropriate imaging services. AUCs are defined as criteria that are evidence-based (to the extent feasible) and assist professionals who order and furnish applicable imaging services to make the most appropriate treatment decision for a specific clinical condition for an individual.

There are four major components of the AUC program required, each with its own implementation date: (1) Establishment of AUC by November 15, 2015; (2) mechanisms for consultation with AUC by April 1, 2016; (3) AUC consultation by ordering professionals and reporting on AUC consultation by furnishing professionals by January 1, 2017; and (4) annual identification of outlier ordering professionals for services furnished after January 1, 2017. In the recent Calendar Year 2016 Physician Fee Schedule (PFS) final rule, we primarily addressed the first component—the process for establishment of AUC, along with relevant aspects of the definitions.

PAMA provides for certain exceptions to the AUC consultation and reporting requirements including in the case of certain emergency services, inpatient services paid under Medicare Part A, and ordering professionals who obtain a hardship exemption. We did not include proposals to implement these exceptions in the CY 2016 PFS rule. It is important that we first establish through notice and comment rulemaking the process by which applicable AUC will be specified

³ <https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf>

as well as the CDS mechanisms through which ordering providers would access them. We anticipate including further discussion and adopting policies regarding the AUC program requirements primarily in the CY 2017 and CY 2018 PFS rulemaking cycles. Therefore, we do not intend to require that ordering professionals meet this requirement by January 1, 2017.

Given the complexity of the program to promote the use of AUC for advanced imaging services, we believe it was imperative to consult with physicians, practitioners and other stakeholders in advance of developing proposals to implement the program. And we will take into consideration the issue you raised as we work on implementing the AUC program.

The Honorable Michael C. Burgess

1. **What is CMS doing to ensure that there are alternative payment model options for physician groups looking for options that are not built on fee-for-service platform but that do not require the massive financial investment of say, an ACO?**

Answer: MACRA established a particular definition of alternative payment models (APMs) and established what qualifies as an “eligible APM,” for purposes of exempting eligible professionals from the Merit-based Incentive Payment System (MIPS) and allowing eligible professionals to receive a special incentive payment as a qualifying APM participant. While creating this new category of eligible APMs provides for promising incentives for a growing number of eligible professionals in the future, we expect the initial years to be ones of development as we apply lessons learned and continue to refine the program. We will continuously search for opportunities to expand the range of options for participation in eligible APMs within the contours of the statute. In keeping with the statute, it is our intent to align the MIPS and APM components of the new payment system to the extent feasible, thus allowing maximum flexibility for physicians and other clinicians who are not yet ready for eligible APMs to participate in MIPS and then migrate to eligible APMs when they are ready. As we move forward with MACRA implementation, we will continue to gather and incorporate feedback from stakeholders as we promote additional physician-focused APMs. CMS looks forward to receiving recommendations for new physician-focused payment models made by the Physician Focused Payment Model Technical Advisory Committee (PTAC).

2. **A goal of MACRA, as well as a major provision of 21st Century Cures, is to deal with the inexcusable lack of interoperability between electronic health record systems. How could CMS potentially restructure the EHR-meaningful use program to ensure that this component of MIPS is more flexible, and is tailored to the needs of specialty practices?**

Answer: As CMS moves forward with implementation of MACRA, we are committed to building a program that fulfills the goals of advancing quality and value while being adaptive to the needs of each clinician’s individual practice and patient population.

In particular, we have been working side by side with physician and consumer communities and have listened to their needs and concerns about the Medicare Electronic Health Record Incentive Program for eligible professionals as we transition it to the Merit-based Incentive Payment

System (MIPS). This work will be guided by several critical principles that promote better care for Medicare beneficiaries:

1. Rewarding providers for the outcomes technology helps them achieve with their patients.
2. Allowing providers the flexibility to customize health IT to their individual practice needs. Technology must be user-centered and support physicians.
3. Leveling the technology playing field to promote innovation, including for start-ups and new entrants, by unlocking electronic health information through open application programming interfaces (APIs) – technology tools that underpin many consumer applications. This way, new apps, analytic tools and plug-ins can be easily connected to so that data can be securely accessed and directed where and when it is needed in order to support patient care.
4. Prioritizing interoperability by implementing federally recognized, national interoperability standards and focusing on real-world uses of technology, like ensuring continuity of care during referrals or finding ways for patients to engage in their own care. We will not tolerate business models that prevent or inhibit the flow of data necessary to meet the needs of the patient.

3. **We have heard concerns regarding the current set of resource use measures used under the Value-based Payment Modifier. Some have argued that they hold physicians accountable for care provided outside of their control, that the measures focus on conditions and diseases that are irrelevant to many specialists, or they are based on total Part A and Part B costs, which is more appropriate for hospital measurement. What steps is CMS taking to ensure the availability of a more relevant and accurate set of resource use measures in time for the first year of MIPS? If CMS is unable to develop additional measures on time, is there a contingency plan to ensure specialists are not inappropriately dinged?**

Answer: CMS issued a Request for Information that invites feedback on many questions related to resource use measures, including whether additional resource use measures should be considered and how resource use should apply to providers in MIPS for whom there may not be applicable resource use measures. The feedback we are receiving will help to inform our proposed rule, and we look forward to receiving additional feedback from stakeholders as part of the rulemaking process.

4. **MACRA created a new category within the MIPS payment system called Clinical Practice Improvement Activities. The idea behind this category was to reward physicians for quality improvement activities that they might already be undertaking but not being acknowledged for such as continuing medical education, expanded office hours and the use of clinical data registries. Does CMS plan to recognize a wide variety of clinical practice improvement activities or focus on a more narrow set?**

Answer: The clinical practice improvement activities performance category of the Merit-based Incentive Payment System (MIPS) is required to include at least the following subcategories (to which the Secretary may add):

1. Expanded practice access
2. Population management
3. Care coordination

4. Beneficiary engagement
5. Patient safety and practice assessment
6. Participation in an Advanced alternative payment model

We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population.

We know that physicians and other clinicians may need assistance in transition to the Merit-based Incentive Payment System (MIPS) and we want to make sure that they have the tools they need to succeed in a redesigned system. In addition, Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as regional extension centers and regional health collaboratives to offer guidance and assistance to physicians and other clinicians. The technical assistance is to focus on the performance categories under MIPS, including the meaningful use of certified electronic health record (EHR) technology category, helping to make it as seamless as possible for these clinicians and practices to comply with MIPS requirements and helping interested practices transition to implementation of and participation in an alternative payment model. We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance.

In addition to the MACRA funding, in September 2015, CMS awarded \$685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and spend dollars more wisely. The Transforming Clinical Practice Initiative is one of the largest federal investments designed to support physicians and other clinicians in all 50 states through collaborative and peer-based learning networks. As with all major implementations, CMS continually assesses resource needs.

As we move forward under MACRA, we will be sharing details and inviting comment as part of the rulemaking process this Spring.

The Honorable Leonard Lance

The spirit and intent of MACRA emphasizes working with and learning from stakeholders in the medical community who are developing alternative payment models and those participating in these new payment models. In particular, medical specialty societies can play an important role, as they lead the development of guidelines and quality metrics in their areas of medicine and increasingly are working to develop alternative payment models.

- 1. Can you describe for the Committee how are you planning to work with specialty organizations/societies in developing alternative payment models to ensure that MACRA implementation is flexible enough and meaningful to allow specialists from across medicine to fully participate?**

Answer: It is vital to engage partners who are also committed to, and have a stake in, improving our health care system, including patients, providers, payers, government, and businesses. This is why we helped launch the Health Care Payment Learning and Action Network (LAN) in March 2015 to bring together stakeholders in the public and private sector to accelerate adoption of value-based payments and alternative payment models (APMs). More than 4,800 patients, insurers, providers, states, consumer groups, employers, and other partners joined the LAN and over 50 organizations have made commitments to payment transformation, including health plans, provider organizations, consumer groups, and state governments. The LAN is working to identify areas of agreement around movement to APMs and is collaborating to generate evidence, share best practices, and remove barriers to success. Just one example of the LAN's work is the development of a detailed framework for APMs, which can be used to describe and measure progress in the adoption of APMs across the U.S. health care system. This framework was released in January 2016 and is only the first step of the LAN's efforts, which are now focused on patient attribution, financial benchmarking, and clinical episodes, among other topics. This example shows that CMS, working with a multitude of partners through the LAN, can help the health care system meet or exceed the Medicare goals for value-based payments and APMs.

In addition, through MACRA, Congress established a new independent advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC meets on a periodic basis to review physician-focused payment models submitted by individuals and stakeholder entities and prepare comments and recommendations on proposals that are received, explaining whether models meet criteria for physician-focused payment models. The 11 members of the PTAC, who were appointed by the Comptroller General, are experts in physician-focused payment models and related delivery of care, including researchers, practicing physicians, and other stakeholders. The first PTAC meeting was held on February 1, 2016, and presentations from the meeting are available online. CMS looks forward to receiving recommendations for new physician-focused payment models. We will need stakeholder engagement with the PTAC, including physicians and other clinicians, to suggest well designed, robust models that could meet the statutory criteria to be an eligible APM.

- 2. It is my understanding that the radiation oncology specialty society has developed models related to breast cancer and palliative care, and they have several more models in the works. Likewise, other radiation therapy stakeholders are developing and testing new models. I think it's important for CMMI to work closely with medical specialties and other stakeholders. Can you describe how you plan to engage radiation oncologists and the broader physician specialty community in the development of these new models for cancer care?**

Answer: The Center for Medicare and Medicaid Innovation (CMS Innovation Center) has a growing portfolio testing various payment and service delivery models that aim to achieve better care for patients, better health for our communities, and lower costs through improvement for our health care system. Efforts include developing new payment and delivery models designed to

improve the effectiveness and efficiency of specialty care. Among those specialty models is the Oncology Care Model, an innovative new payment model for physician practices administering chemotherapy. Under the Oncology Care Model (OCM), practices will enter into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients. CMS is also seeking the participation of other payers in the model. This model aims to provide higher quality, more highly coordinated oncology care at a lower cost to Medicare.

The Innovation Center is actively seeking ideas from the public, including specialty physicians and societies, on how care can be delivered and paid for in ways that will lower the total costs while improving quality. Ideas may be submitted by visiting our website at: <https://innovation.cms.gov/Share-Your-Ideas/index.html>.

In addition, through MACRA, Congress established a new independent advisory committee, the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC meets on a periodic basis to review physician-focused payment models submitted by individuals and stakeholder entities and prepare comments and recommendations on proposals that are received, explaining whether models meet criteria for physician-focused payment models. The 11 members of the PTAC, who were appointed by the Comptroller General, are experts in physician-focused payment models and related delivery of care, including researchers, practicing physicians, and other stakeholders. The first PTAC meeting was held on February 1, 2016, and presentations from the meeting are available online. CMS looks forward to receiving recommendations for new physician-focused payment models. We will need stakeholder engagement with the PTAC, including physicians and other clinicians, to suggest well designed, robust models that could meet the statutory criteria to be an eligible APM.

The Honorable Renee Ellmers

- 1. Does the Department have the authority it needs to ensure that successful participation in the Meaningful Use program and use of technology certified for the Meaningful Use program will enable success in value-based payment, or does the Administration need additional authorities from Congress?**
 - o **If additional authorities are needed, what are they?**

Answer: The Department of Health and Human Services proposed four new legislative authorities for the Office of the National Coordinator in the President's FY 2017 Budget that, if enacted, would improve HHS' ability to facilitate information flow between providers. We have identified opportunities to improve market transparency and reduce information blocking, advance common standards, improve safety, and advance opportunities to support data sharing that are included in our proposals. We believe these proposals strike the right balance between leadership and coordination and will allow us to move these important goals forward to benefit patients, consumers, and providers across the country.

2. **Similarly, do you interpret the MACRA statute, or HITECH for that matter, to enable CMS to manipulate the construct of the Meaningful Use Program to no longer be all-or-nothing for both doctors and hospitals? Or only doctors?**
- **If only for doctors, how do you account for challenges the potential discrepancies in the Program's construct for doctors and hospitals can pose?**
 - **Do you need additional statutory authority to make any changes?**

Answer: Our goal is for the Merit-based Incentive Payment System (MIPS) to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population.

In particular, we have been working side by side with physician and consumer communities and have listened to their needs and concerns about the Medicare Electronic Health Record Incentive Program for eligible professionals as we transition it to MIPS. This work will be guided by several critical principles that promote better care for Medicare beneficiaries:

1. Rewarding providers for the outcomes technology helps them achieve with their patients.
2. Allowing providers the flexibility to customize health IT to their individual practice needs. Technology must be user-centered and support physicians.
3. Leveling the technology playing field to promote innovation, including for start-ups and new entrants, by unlocking electronic health information through open application programming interfaces (APIs) – technology tools that underpin many consumer applications. This way, new apps, analytic tools and plug-ins can be easily connected to so that data can be securely accessed and directed where and when it is needed in order to support patient care.
4. Prioritizing interoperability by implementing federally recognized, national interoperability standards and focusing on real-world uses of technology, like ensuring continuity of care during referrals or finding ways for patients to engage in their own care. We will not tolerate business models that prevent or inhibit the flow of data necessary to meet the needs of the patient.

The forthcoming proposed rule will offer more details, and we look forward to receiving and reviewing comments following its release.

While MACRA only modified the meaningful use program for Medicare clinicians, we are continuing to consider what additional reforms may be permitted under the statute for hospitals which could increase alignment with MIPS.

3. **We hope the Department is quickly progressing in their efforts to equip physicians to be successful under the new payment models, either in MIPS or APMs, given that 2017 is the first program year for physicians under MACRA. We hope to see the proposed rules released soon to ensure the industry has the best chance of success in 2017.**

- **I'd like to hear if the Administration believes physicians are equipped with the technology they need to be successful under MACRA. Especially given the ongoing struggles of providers in the Meaningful Use Program and the lack of nationwide interoperability. Will EHRs certified for the Meaningful Use program enable success in the new world of value-based payment?**
- **Does CMS have the technical capacity to administer these new payment policies?**
- **Does CMS need additional resources to successfully administer the MACRA programs?**

Answer: The clinical practice improvement activities performance category of the Merit-based Incentive Payment System (MIPS) is required to include at least the following subcategories (to which the Secretary may add):

1. Expanded practice access
2. Population management
3. Care coordination
4. Beneficiary engagement
5. Patient safety and practice assessment
6. Participation in an Advanced alternative payment model

We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population.

We know that physicians and other clinicians may need assistance in transition to the Merit-based Incentive Payment System (MIPS) and we want to make sure that they have the tools they need to succeed in a redesigned system. In addition, Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as regional extension centers and regional health collaboratives to offer guidance and assistance to physicians and other clinicians. The technical assistance is to focus on the performance categories under MIPS, including the meaningful use of certified electronic health record (EHR) technology category, helping to make it as seamless as possible for these clinicians and practices to comply with MIPS requirements and helping interested practices transition to implementation of and participation in an alternative payment model. We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance.

In addition to the MACRA funding, in September 2015, CMS awarded \$685 million to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and spend dollars more wisely. The Transforming Clinical Practice Initiative is one of the largest federal investments designed to support physicians and other clinicians in all 50 states through

collaborative and peer-based learning networks. As with all major implementations, CMS continually assesses resource needs.

As we move forward under MACRA, we will be sharing details and inviting comment as part of the rulemaking process this Spring.

4. **As you know, the “Meaningful Use” program was part of the HITECH Act, which was enacted five years prior to MACRA and the accelerated movement to value-based-payment announced last year by the Department.**
5. **Acting Administrator Slavitt said of the Meaningful Use program, “as it [Meaningful Use Program] has existed, will now be effectively over and replaced with something better.” If those changes are being considered by MACRA, can CMS make such changes for the current program year if they are good policy beginning in 2017?**
 - **For example: Can CMS relax the "all or nothing" nature of grading for 2016? Does in 2016 who try and still fail to be meaningful users will receive a whopping -4% reduction in Medicare revenue in 2018, just as they are trying to get used to reporting as they will need to under MIPS.**
 - **CMS should do everything within its regulatory power to keep providers in the program and not take this hit especially since they have the power to lower the bar in a sense.**

Answer 4 & 5: CMS issued a Request for Information that invites feedback on many questions related to meaningful use, including how to determine the performance score for that category in the Merit-based Incentive Payment System (MIPS). The feedback we received will help to inform our proposed rule, and we look forward to receiving additional feedback from stakeholders as part of the rulemaking process.

CMS shares the goal of ensuring eligible professionals and hospitals are successful in the Electronic Health Record Incentive Programs. We will continue to remain responsive to stakeholder input through our rulemaking efforts, the implementation of MACRA, and are committed to helping providers to realize the opportunities health IT presents in achieving the goals of delivery system reform.

6. **How can docs have faith in MIPS and APMs if they don't believe they can be considered meaningful users of HIT, being that 206,000 doctors were subject to Meaningful Use Penalties in 2016? What can we do to ensure physicians have the best chance possible to be successful in the Program in 2016?**

Answer: We know that physicians and other clinicians may need assistance in transition to the Merit-based Incentive Payment System (MIPS) and we want to make sure that they have the tools they need to succeed in a redesigned system. In addition, Congress provided funding in MACRA for technical assistance to small practices, rural practices, and practices in medically underserved health professional shortage areas (HPSAs). This technical assistance could be provided by entities such as regional extension centers and regional health collaboratives to offer

guidance and assistance to physicians and other clinicians. The technical assistance is to focus on the performance categories under MIPS, including the meaningful use of certified electronic health record (EHR) technology category, helping to make it as seamless as possible for these clinicians and practices to comply with MIPS requirements and helping interested practices transition to implementation of and participation in an alternative payment model. We requested feedback from the physician and broader clinician community last year on how best to implement this technical assistance.

7. There's no question that delivery system reform won't be possible without an interoperable healthcare delivery system. What is the Administration doing to advance interoperability? How can the Administration leverage some of the progress that has been made in the private sector to advance interoperability?

Answer: Interoperability is an important part of efforts to make sure that patients get the right care at the right time. The Office of the National Coordinator for Health Information Technology recently released "Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap,"⁴ which describes these efforts in detail.

8. MACRA created a new category within the MIPS payment system called Clinical Practice Improvement Activities. The idea behind this category was to reward physicians for quality improvement activities that they might already be undertaking but not being acknowledged for such as continuing medical education, expanded office hours and the use of clinical data registries. Does CMS plan to recognize a wide variety of clinical practice improvement activities or focus on a more narrow set? Please elaborate on why.

Answer: The clinical practice improvement activities performance category of the Merit-based Incentive Payment System (MIPS) is required to include at least the following subcategories (to which the Secretary may add):

1. Expanded practice access
2. Population management
3. Care coordination
4. Beneficiary engagement
5. Patient safety and practice assessment
6. Participation in an Advanced alternative payment model

We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population. As we move forward under MACRA, we will be sharing details and inviting comment as part of the rulemaking process this Spring.

⁴ <https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf>

9. Will CMS be able to evaluate certified EHR technology to assure it can meet the goals of the EHR quality assessment so that physicians are not penalized for standards that EHRs cannot yet achieve?

10. Congress envisioned MACRA as a means to provide greater flexibility for physicians and not impose new burdens. What is CMS doing to achieve these goals?

Answer 9 & 10: In particular, we have been working side by side with physician and consumer communities and have listened to their needs and concerns about the Medicare Electronic Health Record Incentive Program for eligible professionals as we transition it to the Merit-based Incentive Payment System (MIPS). This work will be guided by several critical principles that promote better care for Medicare beneficiaries:

1. Rewarding providers for the outcomes technology helps them achieve with their patients.
2. Allowing providers the flexibility to customize health IT to their individual practice needs. Technology must be user-centered and support physicians.
3. Leveling the technology playing field to promote innovation, including for start-ups and new entrants, by unlocking electronic health information through open application programming interfaces (APIs) – technology tools that underpin many consumer applications. This way, new apps, analytic tools and plug-ins can be easily connected to so that data can be securely accessed and directed where and when it is needed in order to support patient care.
4. Prioritizing interoperability by implementing federally recognized, national interoperability standards and focusing on real-world uses of technology, like ensuring continuity of care during referrals or finding ways for patients to engage in their own care. We will not tolerate business models that prevent or inhibit the flow of data necessary to meet the needs of the patient.

11. A recent article published in Health Affairs found that physicians are spending \$15.4 billion a year to comply with quality reporting measures that many believe do nothing to improve quality. We know CMS is working on modifying the Meaningful Use requirements, but what is CMS doing to make substantial changes to the problems in the Value Modifier (VM) and Physician Quality Reporting System programs?

Answer: MACRA combines three existing quality programs– the Physician Quality Reporting System, the Physician Value-based Payment Modifier, and the Medicare Electronic Health Record Incentive Program – into one, aligned new program, the Merit-based Incentive Payment System (MIPS) beginning with payments in 2019. Physicians and other clinicians will be evaluated under MIPS based on a single composite performance score, which will factor in performance on four weighted categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified electronic health record technology. We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician’s individual practice and patient population. We look forward to continuing our efforts to gather stakeholder feedback as we proceed with the rulemaking process this Spring.

- 12. Current timeframes for the release of feedback reports are too long, as CMS typically provides feedback reports, often fraught with errors, six to nine months after the close of the reporting period. This delay means that physicians are already well into the next reporting cycle and have no opportunity to change their behavior before they are penalized again. MACRA also calls for CMS to provide timely, valid and reliable data. What is CMS doing to provide more rapid cycle and accurate feedback to physicians so physicians can have the ability to act on the information and engage in meaningful quality improvement?**

Answer: CMS works with physicians to ensure feedback is meaningful and is delivered in a timely manner. In order to best meet providers' needs, CMS has historically had a 3-4 month provider reporting period following a 12 month performance period. CMS then reviews the submitted data, provides feedback, and makes applicable payment adjustments in as timely a manner as possible.

- 13. MACRA did include funding for technical support for small and rural practices, but practices of all sizes are already dealing with long wait times on MACRA's hotline, QualityNet, and long turnaround time on questions submitted via email. When practices do receive information back from QualityNet, sometimes unanswered questions remain, or information is difficult for clinicians to understand. What type of support systems does CMS envision having in place to help all providers and practices with the questions they have as MACRA is being implemented? How will CMS ensure that information and feedback provided to clinicians and practices is clear and actionable?**

Answer: CMS has embarked on a significant outreach effort to engage our users and the clinical community to both develop the policy proposal as well as determine how, once implemented, the clinical community can participate in these programs successfully. Our listening sessions, focus groups, and direct user research (e.g., sitting with clinicians in their offices) have validated the need for a robust communications, education, and training program. We are developing a program that will provide easily accessible resources for all clinicians, many of which will be on-demand so that clinicians can access these resources when it is convenient for them. These materials will focus on helping clinicians understand the programs and how to participate in them successfully. Therefore, the first goal is providing better, easily accessible, and more actionable information to help users self-service successfully and lessen center volumes. Augmenting these efforts is focused field-based training that targets small, rural, clinicians as well as those in health professional shortage areas that will begin in earnest later this year when the rule is finalized. Additionally, CMS will integrate existing programs such as the Transforming Clinical Practices Initiative that has already recruited over 60,000 physicians and clinicians. Programs such as these and working with our federal partners such as HRSA will be very valuable to reaching and preparing front-line clinicians. CMS will work to constantly iterate and improve the education, training, and technical assistance to learn from real-time experiences and input from frontline providers.

CMS is already engaging with medical societies, associations, registries, vendors and other critical channels to gather communications, engagement, and training recommendations and to

use all relevant channels to provide meaningful and actionable information to clinicians of all specialties, geographic representation, and size. The engagement goals are to identify communication and education needs, to ensure that collectively we are developing resources that will help clinicians transition, to push resources to front-line clinicians, and to gather feedback on what's working and what's not. To accomplish this task, we will be engaging field partners at all levels – national, state/regional, as well as local/county level.

As a part of these efforts, CMS is assessing the current Help Desk/customer service solution and we are exploring options to deliver an experience for our users that results in faster, reliable responses regardless of how they choose to seek support. Additionally we are evaluating methods to create mechanisms that will highlight common inquiries to the helpdesk and utilize them to instruct ongoing communication and outreach efforts, as well as generate web based educational content, with the goal of minimizing the need to contact the Service Center for guidance.

Dr. Conway, earlier this month, HHS announced that it had hit their goal of tying 30% of Medicare payments to alternative payment models. The announcement stated this included those participating in the Medicare Shared Savings Program as well as the Center for Medicare and Medicaid Innovation and listed examples of alternative payment models as Accountable Care Organizations (ACOs), advanced primary care medical homes and new bundled payment models. As of January 2016, CMS estimates that \$117 billion out of a projected \$380 billion in Medicare fee-for-service payments are tied to alternative payment models.

CMS reports that there are 477 ACOs participating in the Medicare Shared Savings program and the Pioneer ACO program. These ACOs are broken down as Track 1, Track 2 and Pioneer ACOs.

14. Dr. Conway, can you walk me through CMS's calculation of this \$117 billion? Which types of ACOs were included in reaching this \$117 billion? Track 1 ACOs? Track 2 ACOs? Pioneer ACOs?

Answer: As of January 1, 2016, CMS identified 10 alternative payment models⁵ for tracking our progress towards the Administration's goals, including Pioneer ACOs and Track 1, Track 2, and Track 3 of the Medicare Shared Savings Program.

We conducted a three-step analysis to project total estimated APM expenditure for each model.

- **Step 1—Number of attributed beneficiaries:** Beneficiaries attributed to most models were provided by the model groups using predefined prospective attribution methodologies. Figures were adjusted to account for attrition over the course of the year based on the average historical rates of attrition, where available.

⁵ Medicare Shared Savings Program (MSSP), Pioneer ACOs, Next Generation ACOs, Comprehensive End Stage, Renal Disease Care Model (CEC), Comprehensive Primary Care Model (CPC), Multi-Payer Advanced Primary Care Practice (MAPCP), End Stage Renal Disease Prospective Payment System (ESRD PPS), Maryland All-Payer, Medicare Care Choices Model (MCCM), Bundled Payment Care Improvement (BPCI 2-4)

- Step 2—Multiply by annual cost per beneficiary: Expected annual spending for each beneficiary was provided by model teams. Figures were inflation-adjusted using OACT projections of growth in Medicare Part A and B spending in 2016.
- Step 3—Remove beneficiaries who may participate in more than one model: Participants in non-shared savings models can overlap with a shared savings model. Downward adjustment in non-shared savings models were made based on a uniform distribution of shared savings and non-shared savings models.

The proportion of Fee for Service (FFS) payments tied to APMs was calculated by adding the estimated expenditure for each model—found using the three-step process above—and comparing this to total Medicare FFS spending as projected by OACT.

15. If CMS included all types of ACOs into this calculation, does that mean that CMS considers them all alternative payment models that should be qualified to be considered for MACRA bonuses?

Answer: MACRA established a particular definition of alternative payment models (APMs) and established what qualifies as an “eligible APM,” for purposes of exempting eligible professionals from the Merit-based Incentive Payment System (MIPS) and allowing eligible professionals to receive a special incentive payment as a qualifying APM participant. Later this Spring, we will release a proposed rule that will further define the criteria for an eligible APM, and we look forward to gathering feedback from stakeholders as a part of the rulemaking process.

The Honorable Gene Green

One of the most important Clinical Practice Improvement Activities in which nuclear cardiologists, as well as other physician specialists, engage is consultation with imaging appropriate use criteria (AUC).

Prior to passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress passed the “Protecting Access to Medicare Act of 2014” (PAMA) which establishes that health care professionals must consult AUC prior to referring a patient for an advanced diagnostic imaging test, such as nuclear imaging, computed tomography and magnetic resonance.

1. **What efforts are being made by CMS to ensure that physicians who fulfill the Medicare AUC Program requirements also receive credit for this activity under the Clinical Practice Improvement Activity component of the Merit-Based Incentive Payment System (MIPS)?**
2. **For many specialists, like nuclear cardiologists and radiologists, MIPS and alternative payment models will center on the performance, interpretation and quality of imaging tests. Has CMS considered how the AUC Program requirements could be fulfilled through the MIPS and APMs rather as a stand-alone program, which would allow for consultation of AUC, the goal of the AUC Program, to be measured against robust quality and resource use metrics?**

Answer 1 & 2: Determining how existing provider requirements will fit into the Merit-based Incentive Payment System (MIPS) is a critical part of our ongoing efforts to implement MACRA legislation. We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population. Within the next several weeks, CMS will release a proposed rule addressing many critical aspects of MACRA implementation, such as details on evaluation of MIPS categories. We look forward to receiving comments as part of the rulemaking process.

The Honorable Elliot Engel

- 1. As you know, MACRA included language that afforded the Secretary the authority to develop measures and alternatives to reflect the way non-patient facing physicians practice medicine. These physicians, as you know, do not have regular and direct interaction with patients. How is CMS implementing that provision to enable physicians to comply with the quality programs in the MIPS program**

Answer: The delivery of specialty services, including those provided by non-patient facing physicians, is critical to our health care system. Determining how to evaluate the activities of these providers through the Merit-based Incentive Payment System (MIPS) is a critical part of our ongoing efforts to implement MACRA legislation. We are in the process of developing a scoring methodology that is meaningful, understandable, and flexible. Our goal is for the program to be meaningful to both clinicians and patients and help shape our health system for the better. In implementing MIPS, we are committed to building a program that fulfills the goals of advancing quality and value, while being adaptive to the needs of each clinician's individual practice and patient population. As a part of our Request for Information⁶, we sought comment on a number of questions related to MIPS categories for providers who furnish services that do not involve face-to-face interaction with patients. The feedback we receive in response will help to inform our proposed rule, and we will invite additional comments and feedback as part of the rulemaking process.

⁶ <https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-24906.pdf>

