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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, D.C.

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.

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to review the implementation and progress of the Medicare payment reforms as included in the historic legislation which repealed the Sustainable Growth Rate, the SGR, and replaced it with new payment models and other reforms.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:]

**********COMMITTEE INSERT 1**********

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.

[The statement of Mrs. Blackburn follows:]

**********COMMITTEE INSERT 2**********

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

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 reasonable 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 five years and ensures no changes are made to the current payment system for four 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 meaningful 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 a 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.

[The statement of Mr. Green follows:]

**********COMMITTEE INSERT 3**********

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

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 unprecedented 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 and 92 -- 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 website 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. It is hard to see how -- 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.

[The statement of Mr. Burgess follows:]

**********COMMITTEE INSERT 4**********

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

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:]

**********COMMITTEE INSERT 5**********

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 of 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 remaining time.

[The statement of Ms. Matsui follows:]

**********COMMITTEE INSERT 6**********

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

[The information follows:]

**********COMMITTEE INSERT 7**********

Mr. Pitts. I have also 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 Council, without objection. Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT 8**********

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 five minutes to summarize your testimony, and thank you very much for coming this morning. Dr. Conway, you are recognized for five 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 Program 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:]

**********INSERT 9**********

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 five 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 sunsetting 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 okay 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, it gives additional

flexibility to really focus on interoperability, outcomes for patients, simplifying the program and making is 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 also are broadly through our QIO program and a Transforming Clinical Practice Initiative, which is over a $650 million investment over four years, are 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 -- but the 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 okay. 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 eight minutes left in the floor vote. The chair recognizes Mr. Green, five 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 '14? 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, I think, 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. I think, 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, five 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, sort of 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 think we are -- 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, five 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 nations 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 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, five 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 bit long answer -- and one of those subcategories talks about the level of financial risk.

So I think the key, there is 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. Okay. 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 three or four 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. Okay. 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. They are actually, 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. Okay, 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, five 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 improvement, 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, five 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 five 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. Okay. 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, five 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 towards alternative payment models. You mentioned this initiative in your testimony, but can you elaborate on CMS' 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 five years is substantial, the last three to five 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 nine 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 three 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 got 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. Okay. 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, five 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. -- 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. Okay, 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 deep, deeply engaged physician and clinician workforce.

Mr. Bucshon. Okay. 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, five 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 them 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, five 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, five 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 ten 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 subcommittee 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.]