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MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015: EXAMINING PHYSICIAN EFFORTS TO PREPARE FOR MEDICARE PAYMENT REFORMS

TUESDAY, APRIL 19, 2016

House of Representatives

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:15 a.m., in Room 2322 Rayburn House Office Building, Hon. Joe Pitts [chairman of the subcommittee] presiding.

Members present: Representatives Pitts, Guthrie, Shimkus, Burgess, Lance, Bilirakis, Long, Ellmers, Bucshon, Brooks, Green, Castor, Sarbanes, Matsui, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Staff present: Gary Andres, Staff Director; Rebecca Card,

Assistant Press Secretary; James Paluskiewicz, Professional Staff, Health; Graham Pittman, Legislative Clerk, Health; Jennifer Sherman, Press Secretary; Heidi Stirrup, Policy Coordinator, Health; 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 time of 10:15 having arrived, the subcommittee will come to order. The chair will recognize himself for an opening statement.

Today's hearing is a sequel to our Health Subcommittee's earlier review of the implementation progress of the Medicare payment reforms as included in the Medicare Access and CHIP Reauthorization Act of 2015 -- MACRA -- which repealed the sustainable growth rate and replaced it with new payment models and other reforms.

Through a variety of incentives, MACRA encourages physicians to engage in activities to improve quality, patient experience and outcomes and reduce costs.

Prior to MACRA, physicians not only faced the threat of unsustainable cuts from the SGR, but a series of well-meaning but uncoordinated requirements stacked on top of each other from a variety of reporting requirements.

MACRA seeks to consolidate, streamline and integrate these efforts into a single program. However, rather than wait until CMS issues a proposed rule on how they plan to implement these incentives and program changes, there are steps every practitioner can be taking right now.

Physicians should be thinking about ways they can modernize their practices and participate in current programs to act as a springboard for their preparation for MACRA.

Provider organizations should be developing measures to aid their members and help MACRA's goal of creating meaningful measurements that every provider feels are relevant to them.

Physicians should also start evaluating options available to them, whether the Merit-based Incentive Payment System -- MIPS -- or the Alternative Payment Methods -- APMs -- is right for them both for tomorrow and where they want to direct their practice in the future.

Our hearing today will examine options for ensuring the smoothest transition for our providers, based on what we know today. We expect to hear today from our witnesses who come from diverse backgrounds and training and practice from all over the country in rural and urban settings.

Each are practicing physicians in different arrangements and all have worked with their organizations to provide tools and best practices that other physicians can utilize and learn from to be better positioned to succeed under MACRA.

By the conclusion of today's hearing, our Health Subcommittee will have held two oversight hearings on the implementation of MACRA prior to the issuance of CMS' proposed rule.

As we have demonstrated in our commitment so far, the Energy and Commerce Committee will continue to be vigilant in our bipartisan oversight to ensure MACRA is a success and this will

certainly not be our last hearing on the matter.

My time is expired. I now yield to the ranking member, Mr. Green, five minutes for his opening statement.

Mr. Green. Thank you, Mr. Chairman, and I thank our witnesses for being here today and I want to thank you for this -- the hearing, the second part of our subcommittee's hearing on the implementation of MACRA.

As we know, the Medicare Access and CHIP Reauthorization Act, or MACRA, was signed into law a little over one year ago. This landmark legislation repealed the flawed sustainable growth rate, the SGR, formulated to provide long-term stability to the Medicare physician fee schedule and reward value over volume.

It was critically important that Congress pass and the CMS institute a reasonable responsible payment policy for physicians and Incentivize quality care that spends our dollars wisely.

Now that the historic achievement of finally repealing and replacing the 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. To do so, we need a system that's set up that's fair, smart and sophisticated enough to meet the unique challenges of a variety of providers participating in the Medicare system and their patients.

The physician stakeholder community provided extensive

feedback during the development of MACRA and publicly supported and voted the bill through the passage into law.

Like all of us, the provider community appreciates this important step toward a more rational payment system and share a sense of ownership over it.

I want to thank the stakeholders who continue to work with this subcommittee and CMS to ensure that the legislation works for the spectrum of providers and their Medicare patients.

The emphasis on quality and value that underpins MACRA is consistent with the broader mission that Congress and the administration have engaged in over the last decade beginning with the Affordable Care Act.

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 improvement incentive payment program that will focus the fee for service system on providing quality and value.

The incentive payment program refer erred to as Merit-based Incentive Payment System, or MIPS, consolidates the three existing incentive programs continuing to focus on quality, resource use and a meaningful electronic health record use.

But unlike the past, it does this in a cohesive program that avoids redundancies. MACRA also provides another route to incentivize the movement away from volume-based payments by

giving financial bonuses to providers who participate in alternative payment models, or APMs.

APMs hold great promise but their viability and effectiveness requires sophisticated construction and implementation.

I look forward to hearing from our witnesses about their vision for the APMs, specifically how the model will be designed so that they are relevant to different specialties, different sizes of practice and in line with state-based initiatives and private insurance models.

APM should prioritize measures on outcome, patient experience, care coordination and measures of appropriate use of services. They should also take into account gaps in quality measurements and applicability of such measures across the various health care settings.

It is the intent of Congress that specific quality metrics used will be tailored to different provider specialties and each eligible professional will receive a composite quality score.

The challenges with constructing a system that fully accounts for the variabilities in providers and the type of care they're trained to provide and the patient mix as well as how to meaningfully evaluate quality are significant.

But I believe it can be accomplished. To do so, the Centers for Medicare and Medicaid, CMS, has initiated a rule making

process. A rule is imminent. I know everyone in this room is looking forward to its release by CMS.

When the rule is announced I'm confident we'll see additional stakeholder engagement, collaboration, continuation of the transparent and public process throughout the course of implementation.

MIPs and the opportunity to participate in APMs is just around the corner. Now it's time to start preparing. I look forward to hearing from our panel on how they're instructing their peers to begin to prepare for transition.

This subcommittee will continue to exercise oversight over MACRA implementation, not just today but throughout the rule making process.

And again, Mr. Chairman, I thank you for calling the hearing and a follow-up and I hope we'll have other ones as we go along. Again, we don't want to repeat the problems of 1997.

I yield back.

Mr. Pitts. The chair thanks the gentleman. Now, filling in for chair of the committee, Dr. Burgess, five minutes for opening statement.

Mr. Burgess. Thank you, Mr. Chairman, and thank you, Ranking Member Green, for reminding me why I wake up in a cold sweat at 4:00 o'clock every morning. The word is that the next part of this act does not go as well as the first part.

But last week we had the one-year anniversary of the passage of H.R. 2. Big deal. And this -- now we're all reflecting on the historic accomplishment of permanently and forever repealing the sustainable growth rate formula. And just take -- worthwhile to take a moment to acknowledge.

It could not have come to pass without the commitment of the medical community and the leadership of the Energy and Commerce Committee on both sides of the dais.

The hard work is far from over, however, and we've entered into what I like to consider a five-year cessation of hostilities between the Congress, the agency and doctors and we need to make certain, as Ranking Member Green pointed out, that we get it right during this interval.

So we are now having our second hearing on the implementation phase of the Medicare Access and CHIP Reauthorization Act and I'm glad that this committee does remain dedicated to ensuring that we get this next phase of payment reform right.

In the act, we sought to put power back in the hands of those who actually provide the care so the doctors, not agencies, will help shape government care payments systems of the future.

And I am encouraged that when CMS began the process of implementation of this reform it began with a request for information and I was even more encouraged by the response from doctors.

We had 560-odd responses to that request for information. It is important to note that doctors actively engaging in the regulatory process can't just be at the beginning.

We've got to see this through, and certainly the societies have some obligation to help doctors actually prepare for the implementation of this.

Medicare participation should never subject doctors to the things that we've -- we want our doctors to take care of our Medicare patients.

Some would argue that Congress shouldn't even be in the business but we are and we've been there for 50 years. We might as well do it right if we're going to do it and part of doing it right is we shouldn't punish doctors.

But right now, doctors have to do this -- all of these different quality incentive programs. The piecemeal initiatives have undermined their ability to focus on quality.

So to resolve that problem, the MACRA requires CMS -- all these acronyms -- MACRA requires CMS to streamline the current programs into a single value-based payment structure.

This is called the Merit-based Incentive Payment System and the system is designed to incentivize quality whether a doctor is an independent in rural practice or in a large integrated health care system, and that was an extremely important part of just getting H.R. 2 done.

We had to allow for success in whatever practice or arrangement a doctor was in. We had to meet them where they were.

Now, this transition is not going to happen overnight and I am certain that -- what I am certain of right now is that no doctor is going to face the double digit cuts that they were facing under the SGR. But really, truly, we don't want our doctors to wait until 2019 to begin to take action.

Congress currently is universally condemned for being dysfunctional, ineffective. Not a headline there to the guys writing for the press. I know that.

But when you stop and think about what we accomplished with the overwhelmingly bipartisan passage of H.R. 2, and I would note I went to all the celebratory things down at the White House where the president took credit for it. But, honestly, it wasn't the president's deal. It was the committee's deal and we brought the other committees of jurisdiction, both the House and Senate, along with us and it was truly that bipartisan effort.

Henry Waxman was my co-sponsor on H.R. 2. I mean, that's phenomenal in and of itself when you think of it.

But it isn't just -- and when you look at some of the successes and failures of major health care policy that have come through Congress in the past it's also -- you know, they always say the devil's in the details.

So this is where the devil's in the details and we've got

to get this -- we've got to get this right.

It took two decades to replace the SGR because it was hard to do and it required a certain commitment and a certain suspension of hostilities between Republicans and Democrats on the dais. But we did it because it was the right thing to do, and we're going to be called upon to do that again in the future.

I don't know what form that will take but in other health care policy that certainly we could -- people would do well to follow the template that we provided in the Energy and Commerce Committee.

The policies outlined in H.R. 2 are the result of an open and transparent process which sought input and participation from every doctor, patient, member of Congress, administrative agency and anyone else who professed an interest.

We're at this critical juncture in physician payment reform and we'll only get it right if implementation follows that same open, transparent and bipartisan structure that we use to get this to the president's desk.

I want to thank all of our witnesses for being here today. I sincerely appreciate the efforts of all of the provider groups to help us in going forward.

I look forward to your testimony today and look forward to the next in what will be a series of hearings, Mr. Chairman. I'll yield back.

Mr. Pitts. The chair thanks the gentleman.

The ranking member wants to say something.

Mr. Green. Chairman, I just want to thank my colleague from north Texas. But, you know, I felt the same way about the president because he got the Affordable Care Act called Obamacare and all he had to do is sign his name to it. We had to do the legwork. So I understand how you feel.

Mr. Burgess. Some of us did not do that legwork nor did we vote for it nor will we ever, Mr. Green. So if you want me to refer to that as Greencare in the future I'll be glad to do that.

Mr. Green. All right.

Mr. Burgess. I will be honored to do that because I said that.

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

Mr. Pallone. Thank you, Mr. Chairman.

I think this is an important hearing and I thank the witnesses for being here today.

We're meeting to continue our discussion on one of the great bipartisan success stories of this committee, the Medicare Access and CHIP Reauthorization Act, or MACRA.

Our panel of witnesses practice in a variety of settings across the country and represent diverse expertise and training.

They each have the unique perspective to share with us regarding the implementation of MACRA.

The law put in place a dual track system for providers 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 are most enthused to use alternative payment models, or APMs, which have also proven to increase quality and lower costs.

Today we'll discuss the steps all providers can take to modernize their practices, provide higher quality care for their patients and successfully transition to the new payment models established by MACRA, and this will be our second hearing on MACRA implementation. I'm pleased this committee is performing such thoughtful oversight.

While we know that MACRA is already showing promising results, these hearings are necessary to ensure that the law reaches its full potential and I look forward to discussing the tools and best practices physicians can employ to help make MACRA work effectively for all.

So I just want to yield the remainder of my time to Congresswoman Matsui from California.

Ms. Matsui. Thank you for yielding.

Thank you, Mr. Chairman, for holding this second hearing on MACRA. Last year, we joined together in overhauling the broken SGR system, replacing it with one that incentivizes quality over quantity of care, rewards efficiency and encourages the use of breakthrough technologies that will provide more people access to health care across this country.

I am looking forward to discussing ways we can advance the transitions that are already happening and will accelerate with MACRA.

Today, we are joined by physicians who offer important perspectives and best practices for ensuring that delivery systems continue to make inroads in providing high-quality efficient health care to patients.

One of the ways I believe that we can expand access to care and improve outcomes is through the incorporation of telemedicine and to this new value-based system.

Through telemedicine we truly have the opportunity to better engage patients and their families, improve care coordination with loved ones and maximize efficiency of resources.

As we make inroads into this health system transformation, I look forward to working with you and hearing your perspectives on these important issues. Thank you and I yield back.

Mr. Pitts. The chair thanks the gentlelady. As usual, all

the members' written opening statements will be made a part of the record. I'd like to submit the following documents for the record -- statements from the American College of Cardiology, the American College of Surgeons, the Alliance of Specialty Medicine, the American Society of Clinical Oncology, the Advanced Practice Registered Nursing Organizations, the Infectious Diseases Society of America and comments and a statement from the Medical Group Management Association.

Without objection, so ordered.

[The information follows:]

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

Mr. Pitts. We have one panel today. I'll introduce them in the order of their presentations.

First, Dr. Robert McLean, MD, FACP member of the Board of Regents, chair of the Medical Practice in Quality Committee, American College of Physicians; then Dr. Robert Wergin, MD, FAAFP, board chair of the American Academy of Family Physicians; Dr. Barbara McAneny, MD, immediate past chair of the American Medical Association, and finally, Dr. Jeffery Bailet, MD, MSPH, FACS, executive vice president of the Aurora Health Care, co-president of the Aurora Health Care Medical Group.

Thank you for coming today. Your written testimony will be made a part of the record. You'll be each given five minutes to summarize your testimony.

And so we'll begin by recognizing Dr. McLean for five minutes for his summary.

STATEMENTS OF DR. ROBERT MCLEAN, MD, FACP, ON BEHALF OF AMERICAN COLLEGE OF PHYSICIANS; ROBERT WERGIN, MD, FAAFP, BOARD CHAIR, AMERICAN ACADEMY OF FAMILY PHYSICIANS; BARBARA L. MCANENY, MD, ON BEHALF OF AMERICAN MEDICAL ASSOCIATION; JEFFERY W. BAILET, MD, MSPH, FACS, EXECUTIVE VICE PRESIDENT, AURORA HEALTH CARE, CO-PRESIDENT AURORA HEALTH CARE MEDICAL GROUP

STATEMENT OF DR. MCLEAN

Dr. McLean. Thank you.

My name is Robert McLean. I am pleased to share with you the perspectives of the American College of Physicians on the key issues we believe should be addressed in the implementation of MACRA and what we are doing to prepare our members to be successful under it.

On behalf of the college, I wish to express our appreciation to Chairman Pitts and Ranking Member Green for convening this hearing.

I'm a member of the college's Board of Regents and chair of its medical practice and quality committee. ACP is the nation's largest medical specialty organization representing 143,000 internal medicine physicians and medical student members.

In addition to teaching medical students, residents and fellows Yale, I'm also a full time practicing physician who sees over 80 patients per week as part of the Northeast Medical Group

of the Yale New Haven health system.

We sometimes forget even though it has been only a year what has been achieved by repealing the SGR and replacing it with MACRA.

For years, many looking to improve our health care system have embraced the laudatory goals of the triple aim -- improve the patient experience of care, improve the health of populations and reduce per capita health care costs.

However, when I would mention this to my colleagues in practice I frequently received glazed looks and given their list of real world concerns such as I'm struggling with my electronic health record -- I am overwhelmed with these regulations -- I'm given data on clinical metrics and do not know what to do with it -- my patients are unhappy because I am taking visit time away from them to deal with all of these hassles, and before MACRA repealed the SGR, they would then add and I have to worry every year that my Medicare fees will be cut up to 20 percent or more due to some crazy formula. In that environment, can anyone wonder why there is such concern about physician burnout?

Since MACRA became law, though, I can truly tell my colleagues that there is reason for hope. I tell them that the MACRA law will align and simplify some of the measures and reporting. It will truly reward those who have made investments in advanced practice structures like the patient-centered medical homes and will eliminate the yearly financial anxiety created by

the dreaded SGR. Then those glazed and frustrated looks change dramatically.

With surprise, I'm then asked, you mean that this law really does things that will simplify our lives and practice and allow us to focus more on delivering high-quality care to our patients, and I tell them yes.

One way that MACRA does this is by giving physicians more control over our Medicare payments. As you're aware, the SGR resulted in ever physician's conversion factor being cut by the same scheduled amount no matter how cost effective they were or the quality of care they provided the patients.

MACRA fundamentally changes this because the annual adjustment in each physician's conversion factor starting in 2019 will be based on each physician's own contribution to improving quality and providing care more effectively, giving physicians more control over their annual payments while benefitting patients with better outcomes. I truly believe that MACRA can be a shot in the arm to combat burnout if it is rolled out as Congress intended.

To this end, the college has provided CMS with our views on the priorities it must address as MACRA is implemented. There are three in particular that I'd like to highlight.

Number one, CMS must improve the measures to be used in the quality performance category of MIPS and established less

burdensome reporting as Congress clearly intended when it harmonized existing Medicare quality reporting programs into MIPS.

Number two, ACP is very pleased that MACRA supports patient-centered medical homes through both the MIPS program and as an alternative payment model and has urged CMS to create multiple realistic ways for medical homes to obtain certification.

We are encouraged by CMS's announcement just last week of the Comprehensive Primary Care Plus program, a multi-payer patient-centered medical home initiative which potentially could enable participating practices to qualify for higher payments under MACRA.

And number three, CMS should promote innovation by employing a very broad definition of entities that should be considered eligible APMs as well as create pathways for multiple physician-focused APMs to be accepted.

It isn't just up to CMS to ensure that MACRA is implemented successfully. Professional associations including the ACP must do our part. Our educational efforts include online resources, guides, presentations, articles in our publications and practical tools, all designed to help our members prepare for MACRA. This includes MACRA-specific sessions at our annual scientific meeting to be held here in Washington, D.C. just two weeks from now.

One thing I would like to highlight is the ACP practice advisor, an online interactive tool that offers practices the ability to conduct significant evidence-based quality improvement based on the most up to date clinical guidelines, improve performance on clinical quality measures, implement the principles in the medical home model and improve the overall management of their practice.

While the practice advisor serves to facilitate practice transformation independent of any given payment model, it is particularly relevant to preparing physicians to be successful under MACRA.

Thank you for giving the ACP the opportunity today to share our perspective on what CMS needs to do to ensure that MACRA is implemented as Congress intended and on what we are doing to help our members be prepared to succeed under this landmark law.

Thank you.

[The prepared statement of Dr. McLean follows:]

**********INSERT 2**********

Mr. Pitts. The chair thanks the gentleman. Thank you for your testimony.

We're still having trouble with the mics. So Dr. Wergin, make sure you pull that close to you and make sure the mic is on.

The chair now recognizes Dr. Wergin five minutes for an opening statement.

STATEMENT OF DR. WERGIN

Dr. Wergin. Chairman Pitts, Ranking Member Green and members of the subcommittee, thank you for this opportunity to address you this morning.

My name is Dr. Robert Wergin. I chair the American Academy of Family Physicians board of directors. The AAFP is an organization of 120,000 members. I am pleased to be asked to speak about Medicare Access and CHIP Preauthorization Act implementation.

First of all, I want to thank all of you for your effective bipartisan leadership in repealing the much-despised Medicare SGR and putting into place payment reforms that clearly emphasize value-based health care.

More importantly, thank you for putting together legislation that will make a real and positive different in the lives of your constituents.

MACRA implementation will be a major shift in Medicare in a very short period of time. These changes, as dramatic as they may be in the coming years, are consistent with the key principles of practice transformation that the AAFP has supported for over a decade.

For example, almost ten years ago the AAFP, along with four major primary care organizations developed the joint principles

for the patients that are in a medical home that promotes coordinated care, quality and safety and patient access.

Consistent with those principle we believe that the practice transformation necessary to make MACRA successful will mean better care for patients, better professional experiences for our physicians and better control of health care costs.

We hope it will also bring back the joy of the practice of medicine to our members. As I travel from state to state meeting with AAFP chapters I hear a lot of anxiety related to MACRA, particularly for my colleagues in rural and under served areas.

I challenge my colleagues to be optimistic. MACRA reform will not be easy but it's much better than what physicians faced before the law was enacted. Instead, I urge them to take advantage of the AAFP resources they can utilize to begin transforming their practices now.

The AAFP believes MACRA is by intent and design a law aimed at transforming our health care delivery system into one that is based on a strong foundation of primary care.

As I fully explained in my written testimony, the whole person and complex care that primary care physicians provide helps improve patients' outcomes and constrain overall health care costs, which are also consistent with the law's intention.

Also, the alternative payment models will improve how health care systems value primary care and the services that are

fundamental to disease prevention, chronic care management and population health -- all areas of health care that a fee for service system cannot adequately address.

Although MACRA is among the most significant reforms to occur in decades, many of our members may not be aware of the upcoming changes or do not know their level of readiness for MACRA implementation.

As a result of that, the AAFP has launched a comprehensive multi-year member education and communications effort designed to simplify this transition.

Called MACRA Ready, the effort will include a variety of tactics designed to get the word out to our members starting with a dedicated content page on afp.org.

One of the best primers is an article in the April/March issue of Family Practice Management. Other MACRA content already available to AAFP members are MACRA 101, frequently asked questions, MACRA time line, AAFP news articles, MACRA readiness assessment tool and a MIPS APM calculator and decision tree tool as well.

The AAFP is dedicating considerable time and thought into preparing our members for MACRA and that is reflected in our wealth of available resources. The AAFP is also supporting MACRA implementation by advising CMS about the agency, how the agency might handle many features of the new law which are fully outlined

in my written statement. They include but are not limited to the critical importance of an interoperable electronic health record. The AAFP has also shared recommendations regarding the importance of issuing regulations that are less cumbersome and more user friendly for physicians.

Ultimately, we believe these concerns could be address as the process moves forward and we truly believe that the vision for practice transformation, better patient care, lowering costs and return to the love of the practice of medicine is achievable.

Once again, I want to thank you for your kind invitation to speak about MACRA and its implementation. I look forward to answering your questions.

[The prepared statement of Dr. Wergin follows:]

**********INSERT 3**********

Mr. Pitts. The chair thanks the gentleman.

Now recognizes Dr. McAneny five minutes for opening statement.

STATEMENT OF DR. MCANENY

Dr. McAneny. Good morning. I'm Dr. Barbara McAneny, a hematologist oncologist from New Mexico and immediate past chair of the American Medical Association board of trustees.

Thank you for inviting us to this hearing on MACRA focusing on physician efforts to prepare for Medicare payment reform.

As background, my practice is the New Mexico Cancer Center, which provides multi-disciplinary outpatient cancer care at multiple sites including under served rural areas.

As a practicing physician, I felt the burden of a broken SGR payment system for many years. With half of my patients covered by Medicare, the threat of significant payment cuts was very real and jeopardized the viability of my practice every year.

How could I justify hiring people to provide patient education and care coordination when I would have to lay them off if Medicare cuts went through?

How could I continue to provide services in our most under served area, my Gallup clinic, if the Medicare cuts meant that I couldn't make payroll?

The passage of MACRA now provides physicians with the opportunity to focus on our patients by creating a single performance reporting program, known as MIPS. The law gives us the opportunity to streamline measures, reduce reporting burden

and create flexibility to encourage physicians in every specialty to participate and improve care.

MACRA also promotes innovation by encouraging new alternative payment models. APMs can be tailored to specific patient populations to drive care improvement, leverage technology and promote new treatments.

Importantly, the law acknowledges physician leadership is needed in developing APMs which not only promotes participation but protects patients and can drive down costs.

To ensure physicians can take advantages of these MACRA improvements, the AMA is providing information and resources to physicians. We know that physicians are in many different stages of readiness for MACRA and few have detailed knowledge of the law's requirements.

The AMA is eager to work with CMS so that together we can teach all physicians how to avoid the penalties that could threaten the existence of their practices, especially those working in medically under served areas who lack the resources of larger more affluent areas.

To improve outreach, the AMA has created numerous free online tools and resources to guide physicians. This includes basic information for those with little understanding of MACRA.

The AMA had also created CME training modules that can provide assistance on key issues for MACRAs such as EHR

implementation and team-based care.

We are also helping physicians decide what path, either MIPS or APMs, is right for them by creating a payment evaluator tool to assess their practice. For those interested in moving to alternative payment models, the AMA has created this guide on physician-focused APMs.

This tool walks through seven different models describing the components and benefits of each including examples on how the model could be implemented.

My own experience with APMs have shown that when physicians have the opportunity to innovate, these models can be successful.

In 2012, I received a CMMI grant to replicate across the country how my practice was providing cancer patients with better care at a lower cost.

By implementing a medical home model, we were able to cut hospitalizations in half. This is a model for chronic care management.

CMS must now implement MACRA to ensure that the law successfully achieves the goals intended by Congress. Knowing that the devil can be in the details, the AMA has provided CMS with guidance from physicians to inform its proposed rule.

We have convened specialty and state societies to build consensus and have created a MACRA task for as well as two work groups, one on MIPS and another on APMs, to examine specific issues

related to our program.

In addition to our comment letters and responses to RFIs we've also held listening sessions for CMS and other stakeholders to inform MACRA implementation.

In conclusion, we are hoping the forthcoming regulations from CMS will promote the smooth and successful implementation of MACRA by consolidating and improving current reporting programs, providing broad opportunities for participation in the APMs, addressing current concerns with methodologies of performance measurement and providing physician practices with CMS data needed to evaluate the models.

MACRA provides the opportunity to help every physician in every practice setting make the changes that provide meaningful improvements in the care they give to the patients they serve.

We thank the subcommittee for your continued efforts on this issue and look forward to working with you to ensure a successful start to MACRA.

[The prepared statement of Dr. McAneny follows:]

**********INSERT 4**********

Mr. Pitts. The chair thanks the gentlelady and now recognizes Dr. Bailet five minutes for his opening statement.

STATEMENT OF DR. BAILET

Dr. Bailet. Chairman Pitts, Ranking Member Green and distinguished members of the Energy --

Mr. Pitts. Is your mic on? Yes, just pull it closer. Thanks.

Dr. Bailet. Chairman Pitts, Ranking Member Green and distinguished members of the Energy and Commerce Subcommittee on Health, thank you for the opportunity to testify on behalf of Aurora Health Care, the largest private employer and the largest integrated health care delivery system in the state of Wisconsin.

I am Dr. Jeffery Bailet, co-president of Aurora Health Care Medical Group and one of the largest multi-specialty medical groups in the nation.

As an otolaryngologist head and neck surgeon and medical group co-president, I am responsible for co-leading 2,600 physicians and advanced practice clinicians who provide care to 1.3 million unique patients.

Aurora's diverse delivery system includes several rural community hospitals, urban hospitals, a psychiatric hospital as well as Aurora St. Luke's Medical Center, the state of Wisconsin's largest hospital.

Thank you for extending this opportunity to speak on behalf of MACRA. I am pleased to be a leader of this transition not only

as a medical group physician leader but also as co-chair of the physician-focused Payment-Model Technical Advisory Committee, or PTAC.

I applaud Congress, particularly this committee, for incorporating the PTAC in MACRA as an advisory panel to consider physicians and other stakeholders' proposals for new models of high value care.

I am also fortunate to serve as chair elect of the American Medical Group Association representing medical groups and health systems including some of the nation's largest most prestigious integrated delivery systems.

I am pleased when standing in front of the physicians I support or speaking with physicians across the country that there's no longer debate about the need to transition to value-based care delivery.

Shifting the culture of the health care community to the importance of value is a huge accomplishment and our patients across the country will benefit. It is equally important, however, that regulators appreciate the need to proceed cautiously during this transition.

Many physicians are in various stages of readiness for a value-based payment system. There is and will continue to be a significant learning curve as providers begin to take on financial risk.

When implementing the regulations for MACRA's payment systems, CMS should recognize that the health care system will need time to adapt and learn how to function in this new payment environment. Providing an incremental approach that includes flexibility and rational exposure for financial risk will be vital in ensuring a successful transition to value-based payment.

Congressional oversight of this process is needed and welcomed. Physicians, whether they are in small group practices, larger multi-specialty medical groups or high-performing integrated delivery systems must make significant investments to succeed in a risk-based environment.

For example, Aurora launched a predictive analytic pilot focusing on preventing hospital admissions and readmissions. Using a predictive analytic tool, Aurora was able to stratify a population of heart failure patients who had an 80 percent or higher likelihood of needing to be hospitalized as a result of their disease.

We then redesigned our care approach using health coaches, frequent proactive outreach and engaged patients to take active ownership of their treatment and health status. This effort helped Aurora reduce our congestive heart failure-related admissions by 60 percent.

To help solo and small group practices participate, Aurora is developing clinically integrated networks across our

geographic area. For example, we helped found About Health, a clinically integrated network that enhances clinical quality, increases efficiency and improves customer experiences, providing access to care for about 94 percent of Wisconsin's population.

About Health is an example of how partnerships in Wisconsin between integrated delivery systems and small group practices can create a culture of learning and fostering of best practices to improve quality of care and reduce costs. This effort also helps small groups and solo practices that wish to maintain their independence the ability to do so.

It is vital that CMS continues to engage the stakeholder community. The health care provider community is eager to share its insights with CMS and to date CMS is making a sincere effort to engage.

I encourage CMS to build upon these efforts as value-based parameters are being clearly defined. MACRA represents a realistic opportunity for health care providers to improve the quality of care while reducing health care spending.

High-quality patient outcomes is paramount and the continuous improvement initiatives and redesigned infrastructure we have implemented at Aurora can serve as a guide to other providers.

Also, Aurora seeks out better, more effective ways to deliver

care from our colleagues around the country. Moving forward, Aurora is prepared to fully participate in the development of new risk-based payment models that have the potential to improve patient care and bend the cost curve.

Thank you.

[The prepared statement of Dr. Bailet follows:]

**********INSERT 5**********

Mr. Pitts. The chair thanks the gentleman. Thanks to each of you for your opening statements. We'll now begin questioning. I'll recognize myself for five minutes for that purpose.

I'd like to begin with the APMs and then go to MIPS and we only have five minutes so we'll just go down the line. Dr. McLean, what can physicians do right now to position themselves to succeed under an APM?

Dr. McLean. Well, I think an APM is a larger entity. For either of the two, let me say, to start off I think physicians need to realize that they need to have a good electronic records system.

Most of what we're dealing with now is really dealing with lots of data and a lot of physicians and smaller practices have not had to do that.

They've had to start to if they've been keeping up with PQRS and some of those things but you may know that PQRS I think recently showed that something like 50 percent of physicians in the country didn't even report.

It just wasn't worth the effort to them. They'd rather take the financial hit than kind of putting the systems in place to do so. Now with some of these things I think there's a lot more motivation for physicians and physician groups to actually do that.

So the first thing they need to do is make sure they have

an electronic records system that's able to do a lot of the things that are required here and simplistically.

Mr. Pitts. All right. That's good.

Dr. Wergin, what can physicians do right now to position themselves to succeed in MIPS? Make sure your mic is on. Yes.

Dr. Wergin. Oh. All right. They can go to our website and look at the resources we have.

But for a starting point is recognize quality measures we hope that can be standardized and the collaborative quality measures will be measured and report to PQRS. You need to be a meaningful use provider of electronic health records, which can be challenging.

In my own practice, I made it on the 90th day in the last few hours. I had to call two patients to call me with a question, which was hard because I practice in a Mennonite community who don't have TVs or radios and they don't have computers. So I had to find some non-Mennonites.

You need to do that, and we recommend to our members to move towards the patient-centered medical home. In the MIPS or eventually an alternative payment model we feel that's where you need to move.

Even under MIPS on the fourth criteria you'll get full credit for that and we believe that's a better delivery of care.

Mr. Pitts. Thank you, and without objection we'll make this

part of the record.

[The information follows:]

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

Mr. Pitts. Dr. McAneny, as you may know, this is our second oversight hearing on MACRA even before the proposed rule and this committee will continue to be vigilant in our bipartisan oversight to ensure that MACRA is a success.

Can you speak from both your organization's perspective and that of a physician of why oversight is important and the message you believe it sends to the physician community?

Dr. McAneny. Thank you, Mr. Chairman, for that question. I think it's a very important one. The change in the opinions from CMS that we are now going to have a partnership with physicians to move forward in creating alternative payment mechanisms is probably the most important change that we've seen for a while.

So we -- both as a practicing physician now I have the opportunity to have Medicare payment reflect what I actually do for my patients to free me from the face to face required encounters and let me actually create a system that will manage patients more effectively provides an incredible opportunity.

From the AMA standpoint, we are working very hard to continue to work with CMS. We have provided information at their request for information. We've had listening sessions with CMS.

We continue to convene specialty societies from all around the country to be able to work with their own specialty to try to create alternative payment methodologies that will work in that

specific specialty and we recognize that in different communities with different needs and different levels of resources it will take a different method to provide these alternative payments for them.

So we really have worked a lot with our physician guide to alternative payments, with our website offerings, our Steps Forward program to teach physicians what they need to know right now as they prepare and we very much look forward to seeing the proposed rule.

Mr. Pitts. Before I go to Dr. Bailet, just -- how would you characterize the general physician's knowledge on the repeal of SGR and the passage of MACRA?

Dr. McAneny. Well, I think the general physician is thrilled to have the SGR repealed and to have that taken out from the sword that's hanging over our heads.

The average physician has -- well, there's a huge variation in the amount of information about MACRA. People know that it's there but they don't quite know how it's going to apply to them yet. So all of the specialty societies have their work cut out for them.

Mr. Pitts. Thank you. Thank you.

Dr. Bailet, you note the importance of engaging with the specialist community in the development of APMs. Can you elaborate on where you see growth potential in the future for

specialists playing a bigger role in new care delivery models?

Dr. Bailet. Yes. Specialty care, being a specialist myself, they have a lot of influence on some of the care that's delivered that has a higher price tag and the specialists that I talk to around the country are very actively engaged in trying to influence efficiencies and care delivery and they're very sensitive and aware of the treatments that they're offering and the cost associated with them.

Again, it's a learning curve so the physicians are becoming more familiar with the costs and essentially the end product of the care they deliver and it is a partnership. It is no longer silos of primary care and silos of specialty care.

In order for us to be effective and efficient we need to work together as a team and it's not just physicians, it's also advanced practice clinicians. It's nursing. It's your care team. That is the only way we're going to maximize the potential of the health system and deliver the care the patients deserve at the expense and cost that is rational that will carry us forward.

Mr. Pitts. Thank you. My time has expired.

The chair recognizes Mr. Green five minutes for questions.

Mr. Green. Thank you, Mr. Chairman.

Again, I want to thank our panel and you each represent different specialties and I just want to appreciate you taking your time and away from your practice.

My question of each -- what are you instructing your members to do to prepare for the transition whether under MIPS, fee for service or the alternative payment methods?

Dr. McLean.

Dr. McLean. Well, I think the testimony gets into a little more detail but as other organizations the ACP has been working very hard to put resources together that are available online as well as in multiple publications.

The ACP has worked for years on trying to help internal medicine and its subspecialty practices kind of do the right thing through the practice organization. So for a number of years, there's been stuff on their website and resources about becoming a patient-centered medical home and on how to pick out health records something called EHR partners. So there are resources available to try to make it easier for physicians to go through some decision making on some of those things.

As we now have MIPS and APMs we're taking some of those resources that were already there and developing them into something that's really germane to what we're talking about now so the physicians can have help making the decision. You know, do I -- am I in an organization that's going to qualify as an APM or do I need to kind of go the MIPS path because that's kind of one major fork in the road that people or that physicians will need to decide.

Mr. Pitts. Thank you.

Dr. Wergin.

Dr. Wergin. Well, I think it's -- I hope this is on -- I think it's a challenge for our diverse group. We go from rural communities like mine of 2,000 people up to large health care systems. So we have to go where our members are.

But I think in the long run it still comes down to comprehensive coordinated care. That's what we can provide to an APM. When I go out to states, I am kind of amazed. A lot of people have heard of MACRA but not a lot of details. So we try to begin the education. They're holding back.

We said now is the time to act and move forward to, you know, to being the transformation of your practices to prepare for MACRA.

So we have tools on our websites. When I'm there talking to them for the smaller practice virtual groups or the TPNs or some of the assist granted money that that way can do it to band together and create the infrastructure to keep them alive.

They're important and when they complain I said, do you want to go back to 20 percent cut. In my practice, it's 35 percent Medicare. It would have probably been the end of my practice. I couldn't boutique it. They're my neighbors.

I can't say I can't see Medicare anymore. Couldn't anyway from a business plan. So we want to prepare all our members in

whatever form their practices take and give them the resource to prepare for it.

Mr. Pitts. Dr. McAneny.

Dr. McAneny. Thank you very much.

Again, we start out with the idea that we need to have a tool and we've created one that will help physicians try to learn whether they're better off in MIPS or in MACRA or in the alternative payment model of MACRA.

We also are working very hard to make EMRs -- electronic health records -- into the functionality that they need to have.

One of the very important things that all practices are going to need is to be able to have the date both their own internal data and claims data back from Medicare so that we know how we're doing. And it doesn't help us at all if we get data six months or a year later. How can you change when that happens? You've already lost a year.

So we're trying to work with CMS to modify the electronic health records meaningful use processes so that those become tools that really help us as we engage in patients and not just data collection instruments and we will continue to work, as the others have mentioned, with educating our members as to what their options are, how to get prepared for this, how they can look at creating quality measures.

The other thing that's very important that I think the AMA

is doing is working with multiple specialty societies to create quality measures that are not only good measures but are actually useful as they work to transform their own practices.

Mr. Pitts. Okay. I only have a few seconds left.

Dr. Bailet, I was just wondering -- you know, Congress subjected physicians for 18 years to the SGR and uncertainty. Electronic medical records is such a vital part of what we're doing.

Your accountable care organization, Aurora, is redesigning several approaches to patient care, especially in the area of heart failure and COPD. Can you describe these and also if you're suggesting in your practice and your other physicians anything different than what the other specialties make?

Dr. Bailet. Well, I'm answering the question from the perspective of a medical group leader and I will say that there is anxiety amongst the physicians that I support mostly from not knowing exactly what the rules are going to be, how this is going to play through their practice at the individual level and it behooves us as leaders to support them and to help them understand that we're here -- we're here for that support and unburdening their practice.

The data -- I want to be clear, the electronic health record is the foundation but it is nowhere going to get us where we need to be if we cannot take the data, analyze it and reflect it back

to the practice in ways that are actionable, that are actually going to impact patient care, then it will just be noise that's out there and the physicians will get continually frustrated and they won't be able to do what they need to do for their patients.

So we have to develop a culture of learning, a culture of continuous improvement and to maximize the data in a way, as I said, that it becomes actionable at the patient level. And that is not a small -- that is not a small initiative and undertaking. I want to be clear that yes, you can buy an electronic health record, yes, you can deploy it and yes, you can teach your physicians and clinicians to use it. But until you develop the infrastructure that can analyze it, compartmentalize it, can stratify your patients where you're going to need to deploy your resources in the most critical areas, you're not going to be able to provide the kind of care at the cost that is going to make this successful.

So I just want to caution that it's going to take time build all that infrastructure in and my concern, and maybe that's too strong a word, but my cautions is that we cannot move too quickly.

I know there's a pressing urgency to move forward and I respect that. But I also think if we go too fast and we strip out the physicians who are already struggling with burnout -- one of my colleagues mentioned that today -- this could tip things out of balance and that would take something as wonderful as MACRA

and essentially harm its ability and its effectiveness and I really don't want that to happen.

Mr. Green. Thank you, Mr. Chairman. Thank you.

Mr. Pitts. Chair thanks the gentleman. I now recognize Dr. Burgess five minutes for questions.

Mr. Burgess. Thank you, Mr. Chairman, and I hope our friends at the press table were paying attention to that discussion of Dr. McAneny and Dr. Bailet -- that you all -- I mean, that was some of the most optimistic forward-looking stuff that I've heard. The ability to use predictive analytics, the ability to use data in real time, not two years later -- this is what doctors want to do and the thing that used to bug me about pay for performances I never drove to work in the morning saying, boy, I hope I'm average today.

No, you go to work every day and do your best work and you're talking about why don't we make things so that they can provide doctors the platform to do their best work and that's enormously optimistic.

Dr. Bailet, I'm like you. I mean, I get to go talk to doctor groups all over the country. I recognize that most of the people in the room are my age or older and most of them, if they're not burned out, they're very close and by the time I finish my talk about what we're going to do in their practices they're checking their retirement plan to see how -- you know, how many more days

they have to work, not how many more years.

So this is important. We all recognize we have a person power problem -- manpower, womanpower problem in health care, especially in our physicians and we run the risk of making it worse. And this is one of the things that was so important to me when we tried to reform this.

I think, Dr. Wergin, you said -- you used the phrase it takes the joy out of practice, and I've used that phrase on the floor of the House. Nothing pulls the joy out of the practice of medicine like realizing your Congress is going to whack you off at the knees December 31st every year for, what was it, 17 years.

I mean, that is -- that is a joy-killing exercise if there ever was one. So, again, this is an optimistic hearing today and it's forward-looking hearing and I'm grateful for that.

Dr. McLean, on the -- on this wonderful brochure that -- is this yours or is it Dr. Wergin's? Dr. Wergin. And, you know, unfortunately we don't have this where everyone can see it. But, you know, if you just run through your physician payment time line that you've got over there on the -- on the right hand side, okay, the doctor says, I'm just going to do a darn thing -- I'm sick of Congress, I'm sick of rules, I'm sick of CMS -- I'm not going to do a darn thing.

Well, actually you might wake up in 2019 and realize oh my gosh, I got a 4 percent ding. Now, you didn't get a 27 percent

ding so that's an important point right there but you got a 4 percent ding and you could have gotten a 4 percent bump if you'd just done a little.

So the important thing -- the message here is for those people who are so frustrated they will not lift a finger until 2019 and then they look across the hall and say well, that guy got a 4 percent bump and I got a 4 percent ding -- what do I have to do so I'm in the bump and not the ding group, you can actually start catching up then.

And the folks at Legislative Council and Congressional Research Service and CMS referred to this as everybody gets an A. Well, it's not quite that simple but we wanted it to be simple and we wanted there -- and I think I certainly recognize that there was so much frustration out there that okay, you come at me with a hundred new PLAs -- that's three-letter acronyms -- I'm not -- I'm not there. I'm not going to participate.

In fact, I'm going to retire -- I'm getting out. But if they don't get out and they look around in 2019 I can go from the ding to the bump group and it is not that hard. Many of the things I'm already doing.

I might already be emailing a patient. I might already be involved -- engaged in performance practice enhancement activities and so be eligible for that.

So thank you for making that kind of -- I think it's just

critical that doctors do understand that yeah, a lot of this stuff is really hard in the health care policy but some of it's not and some of it makes sense.

Your Mennonite stuff doesn't make sense with a meaningful use but some of it makes sense. I will also confess to you I used to consider myself basically a medical home for my patients when I was in practice and I was the medical home until the wizards at CMS with administrative pricing decided I wasn't worth it and didn't pay me for it anymore.

So I ran for Congress and that medical home is now abandoned. But it is that concept -- let's do the things for people that actually facilitate what we need done.

And Dr. McAneny, you talked about physician leadership and, you know, that is so critical and this leadership has to come from within medicine itself. It's not going to come from a consultant. It's certainly not going to come from CMS. God knows it's not coming from the Congress.

It's got to come from inside medicine itself. So think you for your efforts in making certain that your constituent members understand that and I'll leave my last second for you to respond to that if you'd like.

Dr. McAneny. If I may, Mr. Chairman.

Mr. Pitts. You may proceed.

Dr. McAneny. The point that you made about we want everybody

to get an A is the most important point because we can't afford to leave any physicians behind when we are facing a physician shortage. WE need to find a path forward for everyone and we need to understand that we're not going to get it right with the first set of regulations.

But we need to make this a rapid-learning process where physicians can try something, not be penalized for it but to have CMS as a partner with all of the specialty societies they work with to be able to move forward and come up with something that better serves the patients of the country.

Mr. Burgess. Great. Leave no doc behind, Mr. Chairman.

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, and thank you all very much for being here today. It's great to hear from folks on the front lines who are taking care of our families and neighbors back home.

You all sound like many of the doctors and physicians that I interact with back home in the Tampa Bay area. They really are enthused about the opportunities of practicing medicine and focusing on value over volume but are a little bit concerned about the transition ahead. So we're really going to need your help and advice as we go along.

First of all, for all of you just a quick answer. Is CMS being proactive with you? Are they open to your comments? I know it's still fairly early in this. Are they -- and do you believe they have the expertise to work with you to develop these alternative payment methods?

Dr. McLean. So thank you. Yes, absolutely. I think that from the get-go since they rolled out the first, I guess, RFI last fall and the ACP -- at least I can speak for them -- sent in I think 40 pages of comments and question/answers and received tremendous feedback on that. There's been an ongoing dialogue between our organization and people at CMS, and then with the second round of questions in the last month or two. So as with everyone else, we're clearly very anxious to see what the final rules are going to be because I'm sure it's not going to be perfect.

Nothing ever is. But I think that thus far CMS has proven to be a very willing participant in conversations as is willing to listen and that's critical.

Ms. Castor. Do you all agree with that?

Dr. Wergin. Yes.

Ms. Castor. Okay. Great.

Dr. Wergin. I would say the same and our response is we feel like they're listening and we respond and try to be very specific and positive in what we would suggest and a key thing is keep it simple and reduce our administrative burden.

Ms. Castor. And Dr. McAneny, you -- in your testimony you raise some points. The population all across the country is not the same and you talked about how these alternative payment methods and MIPS are going to have to be tailored for populations.

How do you think that's going to work in areas of great health disparities? How do we ensure that doctors are available to take on those complex cases that are going to be especially difficult? You wouldn't want medical professionals to be -- to have a disincentive for taking care of those populations.

Dr. McAneny. Well, I think that's very important to avoid any of the disincentives. We need to make sure that as we do quality measures or performance measures that they are very useful for each individual practice.

Making a physician take time away from the patients they serve to answer questions and fill out data fields that have nothing to do with what they do all day takes away a valuable resource of physician time.

What we are trying to do at the AMA is to make sure that we have a variety of tools and recognize that this is going to have to come from the bottom up with CMS and Congress as a partnership rather than as a punitive entity so that when a physician says this would be what would benefit my patients we're hoping that when the proposed rule comes out there will be enough flexibility in that to allow the creativity of physicians to be tested and

to -- if it doesn't work, and not all the models will work, we need to have the ability then to go back and change things without imposing penalties that threaten the existence, particularly of those rural practices and under served areas who are often hanging on by their fingernails now.

Ms. Castor. I agree, and I think we're going to have to be especially mindful.

Dr. McLean, we have a very serious issue with graduate medical education and this arbitrary cap, I think, after the SGR the Congress, with all of your help, we have got to tackle this doctor shortage and focus on GME as well. But setting that aside, are we training the doctors of tomorrow to be ready for this kind of practice?

Maybe we have been all along and then the SGR and volume over value took its toll but what do you see as the future of medical --

Dr. McLean. Interesting question. I think, you know, where -- I think in the last several years when you look at where graduating medical students go into residency there has been an uptick in primary care in medical fields.

So I think that -- until that time I think some of the finances of medical school debt and what potentially am I going to go into as a practice situation -- am I going to -- you know, my income is going to be related to what debt I have to pay was

a big issue for I think a lot of physicians and helped drive physicians away from some of the primary care specialties which tend to be lower paying in aggregate.

I think that the SGR being removed takes that cloud away somewhat. Is it going to drive, you know, a real difference I don't know yet. At the same time, I think people who go into medical care now are going into it really for the right reasons.

They know that it's a complex field and it's remarkably complex and they want to take care of patients, and in some cases I think there's much more education on systems and big data and how do you fix populations. Population health is really a new concept in the last five or ten years and I think there's a bit more education about it at medical schools. So I think that they have a better sense of what they're going to need to deal with going forward.

Ms. Castor. Thank you very much.

Mr. Pitts. The gentlelady's time has expired. The chair now recognizes the vice chair of the subcommittee, Mr. Guthrie, five minutes for questions.

Mr. Guthrie. Thank you. Thank you all for being here, and I met with a group -- a physician group yesterday and they were asking a lot of questions about alternative payment models and so forth, and my point to them was if -- you know, if a few dozen people or so sit in Washington, DC in a room and design all of

this it's not going to be successful. It's got to be from physicians up -- from practitioners moving up so that we can take it into account.

So this panel is important and I appreciate the opportunity to have you guys before us and eagerly look for your input as we move forward because that's how it's going to work.

But we're also eagerly awaiting the proposed rule but I want to know about the proposed rule what are you guys most excited about? I'll just open it to the panel. I'll start to my left and start with Dr. McLean. What are you the most excited about by the opportunities that MACRA offers?

Dr. McLean. You know, I think to echo what Dr. Bailet said, I think the idea that we can take a lot of data that's been floating around out there that we've been collecting in many ways and actually make it actionable incentivize is extremely exciting.

There's a lot of -- there's a lot of information on clinical guidelines that come out of there. Sometimes they changed from week to week, depending upon the topic and the organization that puts it out there.

But physicians are confused -- do I need to follow this or not. But clinical guidelines are a part of clinical practice. There are clinical measures that have been out there.

Some are good, some are bad. How do we use them? If those kind of elements of clinical practice and trying to improve how

well we can deliver high-quality care can be systematically kind of put into a situation where doctors are incentivized to use this data well.

The electronic records that to some extent are almost a necessity are configured to use those elements well we can make a part of daily flow -- work flow -- and patients' care will be better and more reliable and safer and physicians will be happier because they're not checking off all these boxes just because CMS told them to. There's actually a rhyme behind the reason and it's been missing that up until now, I think.

Mr. Guthrie. Okay. Do you want to add? That was a pretty comprehensive answer but we'll -- go ahead, I'll let you guys --

Dr. Wergin. I would just say personally and for my members we're excited about the opportunity to value primary care appropriately which hasn't always been done and it was mentioned we need more primary care family physicians across this country in any setting -- urban, rural, under served -- and that's an opportunity that finally moved us up to the plate. We're excited about transforming our practices to patient-centered medical homes whether they be in the MIPS or APM models because our studies show that the physicians are happier.

They're there to see patients, not click boxes, not try to meet all these arbitrary guidelines or requirements, and I think that's what team-based patient-centered medical home can do.

So I think valuing primary care more appropriately will give us resources to think outside the box, not face to face care all the time -- all the other parameters that we can use. So we're excited about it.

Dr. McAneny. Thank you for that question. Personally what I'm most excited about is that a week and a half ago my practice was selected to participate in the oncology care model, which is one of the, hopefully, alternative payments and we're one of ten practices in the country that's certified as an oncology medical home. So I'm hoping that the proposed rule will come out and say yes, that is an alternative payment.

I'm also very excited about the idea that electronic medical records will become interoperable so I can share data with other people who are taking care of my patients without having to fax records back and forth and to be able to use the alternative payment from the oncology care model to maybe be able to hire a social worker.

I haven't been able to afford a social worker. Or perhaps a dietician to help my patients or nurses to have more time to spend educating patients about their choices.

So I think what I see in my own particular practice will translate very well across the country and the AMA is going to work very hard with all of the specialty societies to find models that can make them as excited about what they're doing as I am

about what I'm doing.

Mr. Guthrie. Okay. So let me ask another question. We'll start with you, Dr. Bailet, and we'll work back the other way this time.

So when we passed MACRA we envisioned it as a means to provide greater flexibility for physicians and not impose new burdens. Can you speak to the current burdens associated with quality programs in your practices and how you believe MACRA can lower the administrative burden while focusing on quality?

Dr. Bailet. I think my colleagues will agree there's so much repetitive reporting, overlap, gaps. It's incredibly burdensome on the reporting today and I'm hopeful that in -- you know, hopeful that the legislation will address that going forward.

I think that that's one of the biggest pieces and also how we engage the physicians with the reporting. I mean, there is in my own practice to some degree there is -- there are gaps and disconnects where the reporting is a little down field.

It's not direct line of sight. So physicians want to do the right thing and we have to provide the information to them in a way that allows them to make changes that are relevant in the moment.

And I would say that our current system doesn't allow us to do that. I know you changed your question but I had an answer.

Mr. Guthrie. Go ahead.

Dr. Bailet. But it's okay --

Mr. Guthrie. Yes, as long as the chair --

Mr. Pitts. Go ahead.

Dr. Bailet. I think MACRA has the opportunity to unleash innovation. We are essentially going to transform the care delivery. This is a very single moment in time where we're going to make an impact and rally physicians and clinicians around giving them ways and tools to better manage their patients and provide and reflect back to them results that actually make a difference.

And we need to create the aura of desirability at a national level where it becomes group agnostic. The best practices, once identified, need to get pushed out quickly and I think these incentives will help foster that. So that, to me, is one of the most exciting things about the position that we're in now.

Mr. Guthrie. Thank you. I do have more questions but I'm out of time so I'll yield back.

Mr. Pitts. The chair thanks the gentleman and now recognized the gentleman, Dr. Schrader, five minutes for questions.

Mr. Schrader. Thank you, Mr. Chairman. Interesting panel and interesting discussion. It is nice to hear a fairly upbeat panel in front of us these days and you're at the ground zero for making this whole thing work and I guess our job is to hopefully

help you that way.

A question -- doesn't matter, Dr. Wergin, I guess -- how to the incentives, in your opinion, on MIPS and the APMs align in terms of the dollar value?

Dr. Wergin. Well, I think one of the things we supplied to CMS is if you base your quality payments or your value-based payments on the old fee for service world, we were relatively under valued. So we hope that they won't use those criteria -- the complexity and intensity of visits we have.

But in general, I think we're not afraid to be -- step forward and have that comprehensive coordinated care piece that we do and I'd be remiss if I didn't mention quality measures.

When I have diabetics come into my practice and say what should my numbers be, doctor, I have to ask them what insurance do you have because if you're Blue Cross it's this -- if it's United Health Care.

Huge opportunity for MACRA to say these are evidence-based standardized guidelines. Then I know what the field is like and can get them there.

Mr. Schrader. So who decides the quality measures that are -- how much do the physicians or other medical providers play into that?

Dr. Wergin. Well, again, it goes back to the payers and I think CMS has had a collaborative group, said 21, not 165 -- that's

the other thing that can be great.

Usually in my area with six or seven different plans, payers, it's set by the payer and there is physician input in that but they vary slightly, each one. So you can be a prime five-star physician in one and a one-star bum in the other, just depending on where you're at and how they set their parameters.

Mr. Schrader. So Dr. McAneny, is there -- is there a form right now for medical providers to share in ways to succeed under a MIPS or APM model?

Dr. McAneny. I don't think we have a -- set up a forum for that. But one of the things we're trying to do both through our innovators committee and through the AMA network of physicians working with all the specialty societies is to try to do some rapid learning and bring some of those forward.

Mr. Schrader. I think it would be a good idea to make sure folks could share and, you know, hey, I'm on -- I'm doing the MIPS thing and here's how I succeed -- here's -- I'm going APMs and here's a way you could succeed there.

You know, a lot of -- to your guys' points these are small business men and women just trying to, you know, keep their practice open in addition to practicing great medicine and so they're going to need some help. Their practice managers, hopefully, would be able to access some of the -- some of the data.

Dr. Bailet, with regard to EHR, I mean, I hear a lot of

conflicting things when I go back home from my medical community. It's yeah, it's really good -- we're getting into that interoperability or geez, it's terrible -- I can't get my lab report to speak to my physician office, you know, and my -- I come from Oregon.

In my state it's all pretty much Epic and so I'm totally confused as to if we're winning or losing on the EHR front. And then to your comment, you know, the feedback to the physician or to the office -- maybe it's not the physician, maybe it's the practice manager about hey, you know, I'm reading all this stuff and it looks like if I treat this pancreatic patient this way, based on national data that we've helped supply, is that stuff out there or is that the stuff you're talking about hopefully will come?

Dr. Bailet. Well, I think it's -- I think it's embryonic. I mean, it's coming on but it is not ubiquitous across the system right now. I think that, you know, electronic health records are not perfect and no one has quite figured it out.

Epic, obviously, comes from Wisconsin. We transitioned. We were Cerner's largest client in the United States. We had deployed it fully across our system and we decided after 20 years it did not give us the lift that we needed going forward and we changed it out, $300 million later.

That is no small undertaking and I do believe there's not

a CPT code that you can charge for changing out your EHR.

Mr. Schrader. Probably not.

Dr. Bailet. But we believed, again, that was the -- that's just the platform. So yes, there are predictive analytic models out there and I'm not advertising for one versus the other.

But they're just beginning to demonstrate the power and, again, approaching the diseases that matter. So heart failure, COPD, diabetes -- these are the diseases where a lot of funds are being expended on behalf of our patients and I know a lot of our conversation has been talking about the financial piece.

Obviously, that's important. But I think we cannot -- we cannot minimize the impact on really transforming patients and what we were able to do at Aurora by changing their health status.

So they were -- they had a sort of -- they were going down a track of outcomes. We were able to take them off that track and improve their health status which, again, that's where the predictive analytic tool provided us the insights to be able to do that. That is significant.

Mr. Schrader. Excellent. I yield back, Mr. Chairman. Thank you all very much.

Mr. Pitts. Chair thanks the gentleman and now recognizes the gentleman from Indiana, Dr. Bucshon, five minutes for questions.

Mr. Bucshon. Thank you, Mr. Chairman. Thank you for

holding this hearing. Thank you all for being here.

I was a health care provider before and a heart surgeon, as probably many of you may or may not know. I trained at the Medical College of Wisconsin in Milwaukee, which Dr. Bailet is familiar with.

Dr. Bailet. Yes. Yes, I am.

Mr. Bucshon. I'm going to make a couple of things -- first of all, just to remind everyone, you know, provider reimbursement is about 8 to 10 percent of the overall health care dollar.

Obviously, MACRA was really -- is extremely important but getting it right is even more important. But I think it's important for the American public to know that we still continue to have cost challenges in our health care system and addressing things at the provider level is only one part of the equation.

That's where, you know, I hope we're not talking about a zero sum game when it comes to specialists and primary care because primary care clearly has been under valued in our system.

That said, also as a specialist I can say that, you know, specialists are also very important. And so if we end up doing this very -- this poorly where we address this as a zero sum game, resulting in provider reimbursement cuts for quality care depending on what type of medicine that you practice, the only thing that's really going to result is access issues for the America's seniors because of the -- what I said earlier. It's

only 8 to 10 percent of the overall health care dollar. That's why these hearings are extremely important.

So since I trained at the Medical College of Wisconsin I'm going to ask Dr. Bailet --

Dr. Bailet. I knew it was coming -- a question.

Mr. Bucshon. No, I -- I know you're not testifying on behalf of this but you were selected to chair the Physician Technical Advisory Committee, PTAC.

Dr. Bailet. Yes.

Mr. Bucshon. Can you just kind of go over and explain briefly to the committee what you perceive as the role of PTAC -- -

Dr. Bailet. Sure.

Mr. Bucshon. -- why you wanted to be part of it and what role you think it's going to play in development of physician-led APMs.

Dr. Bailet. So PTAC was set up to be an independent advisory committee that advises the secretary of HHS on alternative payment models specifically related to physician-focused payment models.

The committee started in January. We had our first public meeting in February. We have our second public meeting in May.

As the chair, my goal is to because, again, the rules have not been released so the activities of the committee we are functioning and spending a lot of time familiarizing ourselves

with each other because this committee needs to work at a high level.

We're also right now creating bylaws and rules of engagement so that when the rules are out we will be prepared to start looking at model proposals straightaway.

One of the areas that we're working on and we're looking at stakeholder input right now is what is the scoring system the committee is going to use to look at models -- what are we going to look at as it relates to important elements -- what weight will those individual elements get.

We want to be able to have a transparent process that the stakeholders have input into developing with us but more importantly that they understand when they're submitting models that the process for submission is streamlined, they know what needs to be in their models. We're going to provide assistance as best we can for select submitters and, again, we're advising.

If you ask me two years from now what would I consider a success for the PTAC committee it would be that the committee has the level of credibility with the stakeholders but also the secretary and our recommendations have a high level of influence and we are willing and able to put together recommendations for models that in fact CMS will see the merits and undertake them.

Mr. Bucshon. That's great, and I had a conversation with CMS earlier this week about the RUC recommendations on provider

reimbursement and I also spoke to them about PTAC and my hope would be as exactly as you say is that the recommendations that you're going to be creating in a very thoughtful and fact-based process, through a thoughtful and fact-based process we'll be taking into serious consideration in contrast to sometimes RUC recommendations on provider reimbursement which seem to mostly be ignored.

So developing these APMs can be a -- I don't want to necessarily focus on you but this -- but I have this question for you. It can be very difficult for small specialties in diverse skills and medicines.

Can you maybe -- and anyone can discuss this -- can you discuss the challenges with that and how PTAC might be able to engage in that discussion to help smaller practices and, you know, we talk about rural communities and others developing and participating in APMs.

Dr. Bailet. Well, I'll be brief and let my colleagues also answer. The PTAC needs to be reflective of the fabric of the United States and the care systems that are delivered from rural communities.

We have communities in Wisconsin of towns of a thousand that we have to provide care for. So we need to as we look at models make sure that it's inclusive of the population that we're trying to treat.

So yes, there will be large metropolitan communities and specialties that can put forth models but we also have to make sure that the elements of the model as we weight them reflect and respect the smaller communities and allow them to participate and --

Mr. Bucshon. My time has expired so --

Dr. Bailet. Oh, I'm sorry.

Mr. Bucshon. -- and I appreciate that input and I would just reiterate that we do have to make sure that all of our communities are included. Thank you.

Mr. Pitts. Chair thanks the gentleman and recognize Mr. Cardenas five minutes for questions.

Mr. Cardenas. So thank you very much for enlightening us with your information and hopefully we'll learn more about what's going on in the streets and corridors of your side of the world.

But in a nutshell, if you could please expand on at least one example of how we could make sure that what is going on is being implemented for the benefit of our constituents, maybe some things that need to be clarified or at least one example of what we can help you do better.

Dr. Wergin. I could start off. The one area that I think it's interoperability of electronic health record, and again, being a rural family physician that treats children to adults who sometimes or in other urban ERs I get 18-page fax notes from an

ER that I have to go in and ask the patient why did you go to the ER and what did they do -- I can see your mother was of Mediterranean descent but I don't think that's why you went to the ER. There's lots of information there. It's faxed into my record, making it nonsearchable.

So I think one thing we could do is set a platform to push the vendors to say you have to have some level of interoperability that it will help me take care of your mother or your child when I have to coordinate that care, and that's important.

And one other point I'd make, if you look at Medicare expenditures 1 percent costs 23 percent, 5 percent costs 50 percent, I think the rule of thumb there is don't let them get in the 5 percent or 1 percent. That's my job.

Dr. McAneny. I would add to that that one of the concerns that we have is what is nominal risk and defining nominal risk in such a way that I as a small practice managing physician can cope with it.

For me, since I am not an insurance company, I do not have reserves. There's other types of risk besides financial risk. If I hire a new employee I'm guaranteeing a salary and benefits.

To me, that's financial risk. If I'm leaving gaps in my schedule for same day patients to me that's financial risk. So one thing that Congress in particular and this committee definitely can help with is to let CMS work with us for that

understanding of risk and also let practices as they develop their measures give us a chance to try that.

Help us along with what we need to learn from the PTAC and from the AMA and from other organizations so that we can try things. Some of it won't work but don't put us out of business if it doesn't work because then we can't serve the patients in that community.

Mr. Cardenas. So we're not -- just so the people watching on SPAN are clear, you're not talking about trying things that puts the patient at risk -- you're just talking about administrative aspects of how to be more efficient and do a better job?

Dr. McAneny. I apologize for that. You're absolutely correct. New structures of care -- if we try a specific team approach if it doesn't save money but it delivers better care we don't want that one thrown out, the baby with the bath water.

Dr. Bailet. Yes, I would agree. I think the flexibility is absolutely key that things like the definition of what's nominal risk that may come out in the proposed rules but I think that's a big uncertainty -- what does that mean -- and I think the goal is to broaden the appeal of this to different size, different geographic area so that everyone can be trying to do this right.

But it's going to take some trial and error in some ways in

terms of how physician practices do it. Clearly, we don't want any sort of risk to be at the level of the patient.

mean, there are other things where I think things need to be done well and carefully and thus far CMS has done, I think, a good job of getting our organization's input on how to do it right but things like patient attribution, risk adjustment -- those are really complicated concepts and I think it would really frighten physicians if they thought that bureaucrats in Washington were making those determinations and not the physicians who actually understand that a bit better.

So I think really kind of making sure that CMS is going through that process the right way with the appropriate input, which they've done so far, is probably one of the most important things that you guys can do.

Mr. Cardenas. In the interest of time, I would love to hear more dialogue but my time is winding down. But how many of you have had the opportunity to personally get to know how health care is delivered in another country? So if you have, please say yes. If you haven't -- it's not a criticism. I'm just curious because a lot of Americans think that we're embarking on models and practices that nobody in the world has ever done and I don't think that's true.

Heaven forbid we would admire another country for what they do. We wouldn't do that as Americans but have any of you actually

been to another country in the health care space and got to see what they do? Yes or no.

Dr. Bailet. Yes. Yes.

Mr. Cardenas. Yes? One? So two yes, two no. Well, in the interest of time, a million more questions but not enough time. But thank you so much, Doctor, Doctor, Doctor, Doctor. Thank you.

Mr. Pitts. Chair thanks the gentleman and now recognizes the gentlelady from North Caroling, Mrs. Ellmers, five minutes for questions.

Ms. Ellmers. Thank you, Mr. Chairman, and thank you to our panel. I'm going to follow up on the gentleman's line of questioning because I was going to ask about nominal risk and how we should be best defining and in your opinion -- and this is going to go to the entire panel -- on some more of this discussion because I think this is very, very important, especially for individual physician practices.

You know, we sometimes take the hospital setting which, obviously, has a little bit more ability to incorporate and utilize those resources for a better product where our physician practices, you know, really have minimal resources to dedicate.

So, one, you know, and it goes into the discussion of interoperability. That has to be part of what is considered in that risk as well, I believe.

So I look at risk as how are we able to better empower our

physician offices to be able to -- to have that ability to share information, one, the infrastructure itself, the HIT -- the health records themselves and establishing the personnel.

And this is kind of that conversation that we've been having now for a couple of years and the promises that were made initially that, you know, we were just going to go through this learning curve and everyone was going to be in a better place obviously has not taken place yet and it's very difficult for our physician offices, especially with all of the other rules, regulations, changes in health care that have taken place.

So I guess I just want to hear a little bit more conversation from all of you on what we do need to be doing here in Congress to help all those things, especially when it comes to the interoperability.

How can we help physician offices to be able to have that knowledge on that patient when they come to the office after being seen in the emergency room? How can we make sure that that information is being shared and how can we better help our physicians to incorporate that as the risk that they're assessing?

Dr. McLean. So I think that the interoperability is, obviously, a big issue and I think has been one of the frustrations that even as physicians have gotten into electronic health records they can't access data elsewhere, and what I'd mentioned earlier -- big data.

You know, part of big data is big data at the small practice level and what do I need to access and my patient, who was at an ER at another part of the state. But then there's also the big data of if in fact my practice small or large is looking at my population of patients and my population health, which is kind of whole other concept when you're looking at trying to deliver good care, making sure that, you know, all of my diabetics have X, Y and Z done because there are people that fall between the cracks.

And until you're able to look at big data and have the analytics to do it you don't even know that. Everyone thinks they're doing a great job until they actually look at the data and they realize that there are things that they're missing despite their good intentions.

So interoperability is key to that and I think that while there are different state initiatives that have tried to break down some of those barriers I think at least in Connecticut it has not worked well.

There was kind or a commission that was trying to do it. It just didn't happen. I think other states have done it very successfully. I think Rhode Island in particular, if I can think of one.

But I think a federal guide to making interoperability happen because people need care across state lines. So even if you have

rules in one state it's not going to necessarily, you know, work.

So it's really incredibly important to allow for accessibility of data for direct patient care but also for the big picture of big data analytics and data management when you're looking at trying to take care of your population of people.

Ms. Ellmers. All right. Thank you.

Dr. Wergin. I had a comment about virtual or the virtual risk and especially, again, being in a small practice which, you know, there are actuarial pools of patients but if you're in a small limited area or geographic you can do it with virtual groups to get larger numbers of patients.

But what -- how do you define what the nominal risk is for that pool and that comes down also to the attribution process. We'd hope it would be prospectus -- that we know what patients were.

In primary care we're responsible for and set up treatment plans and ahead of time rather than what it -- how it usually is. You get a list of patients and say who are these ten people -- I don't even know who they are.

So we need to know that, but a way to make these smaller practices pull together if there's -- if that's how they're going to define nominal risk.

Dr. McAneny. A couple ideas that I would love to throw out. One is that a lot of states have tried to create health information

exchanges yet some of the big institutions put walls around their data so that they can keep the patients to themselves and not let them go elsewhere.

Those walls need to come down so that we can take care of patients wherever the patients want to be taken care of.

The law of small numbers concerns me a lot in the attribution. If my primary care colleagues happen to have ten patients with cancer that year instead of the five that they thought they would and my expensive drugs become attributed to them, they will have a problem in trying to be compared fairly.

So we're very concerned about being able to have good attribution and that's still a science in its infancy. And the other thing that will help a lot is if we can get Medicare claims data back to us in a timely fashion because if I can see a problem and I can figure out a way to fix it, that gives me a lot more ability to take care of patients than if I learn about something two years later when I don't even remember or have any idea what I did right or wrong.

Ms. Ellmers. Right. Absolutely. And I do want to add to your comment about, for instance, patients with cancer and, you know, the smaller practice because I know that, you know, CMS is proposing some more changes to Medicare Part B drug reimbursement and that is going to play in -- and just there again if you don't mind commenting.

I didn't really want to go into that aspect of this because it kind of gets into the weeds. But how do you think that plays into this conversation that we're having today? Do you agree that it'll become more difficult I guess is what I'm asking.

Dr. McAneny. Well, we didn't come here to talk about the ASP changes so I'd be happy to talk with you offline about that issue. But yes, it's very important to us.

Ms. Ellmers. And we will follow up with you on that. Thank you.

Dr. McAneny. I will.

Ms. Ellmers. Dr. Bailet.

Dr. Bailet. So I concur the interoperability is a problem. I think that feedback so the CMS is going to be tasked with providing real time feedback on profiles of their effectiveness particularly in the MIPS and alternative payment models.

So I, again, fundamentally believe, having led physicians for a number of years they want to do the right thing and they will respond to data that is meaningful and when they look at it it says, you know, this reflects my practice.

So that feedback is going to be important. So getting access to the claims data but in a way where, again, it's real time and it can make a difference. If it's too far out of line of sight the impact is going to be limited. So I think in the interests of time I would stop there.

Ms. Ellmers. Well, I just thank you so much and we went way over and I ask apology from the chairman. But thank you and thank you to the panel.

Mr. Pitts. Chair thanks the gentlelady and now recognize the gentleman from Missouri, Mr. Long, five minutes for questions.

Mr. Long. Thank you, Mr. Chairman, and I am not a doctor but I did play one on the -- play one on the radio for several years and I remember my first trip to my doctor on one of my semiannual visits after the passage of some call it Obamacare, others call it Greencare.

But we -- from somebody from Texas it's hard not to get the word out. But on that visit to the doctor right after Obamacare had passed I thought I was going to have to prescribe him a blood pressure medication because he said -- at the end of my visit he said, you sit right there -- he said, you're going to sit there and I'm going to turn around and I've got to enter all this into the computer.

He said it used to be -- remember what used happen? He said, I'd send you out and you'd get your next visit and you'd be out of here but you sit right there while I enter this.

He was several years from retirement age and he retired about six months after that. Such as my district director's doctor also retired. I could go down the laundry list of people that have retired -- doctors that have retired.

And I do have something in common with the author of this, Mr. Green. Both of us have daughters that are doctors and my daughter is a pediatrician who's in her first year -- wrapping up her first year of residency.

So I'm sure the young doctors out there as my daughter is coming on want to know what's going to be out there in the future.

So with that being said, Dr. Wergin, you bring several unique perspectives to the panel. Can you describe some of the specific challenges of practicing in rural areas?

I have a lot of rural areas in my congressional district and the pressures providers in similar situations face to remain in practice like my doctor. Can I ask you to pull your microphone a little closer?

Dr. Wergin. Okay.

Mr. Long. I think we've needed that all day.

Dr. Wergin. Okay. Yes, I think the rural providers that I represent and I represent personally -- I am one -- that you have limited resource. Mental health services, for one, are tough. That's where telehealth might be able to help us. But we need infrastructure to do that.

I mean, they don't do it. But really finding the resources in your communities and identifying them and you have to be in -- meaning using church groups. I use church groups for people that run out of food and it's kind of nice because I don't have

to give them five years of tax forms and all that. I just call the minister and say, this lady is out of food. So identifying resources in my rural areas and the challenges there.

The other thing is burnout. Your patients love you and they almost love you to death. In our -- in primary care our care is delivered. We're a continuous time in a relationship, tremendous confidence in my care.

Sometimes I even have trouble getting patients to go to other providers and like Dr. Bucshon -- they say, well, can't you put my new aortic valve in, Dr. Wergin, and I have to say no, I got to draw the line somewhere on comprehensive.

So I think that relationship-based care, and then I think the other thing we see is how do you recruit people -- the millennials into rural-based care and in rural states I'm sure you face that is how do you -- debt relief, there's carrots out there you can give them but who's going to take my place, et cetera.

But the resource utilization you have, especially care, is usually miles away but they're great in creating that and systems like in Wisconsin are a way to do it.

But it's a rewarding career but we have to sell that to the medical students and mainly their wives because they're going to move to a rural area.

Dr. Bailet. Or husbands.

Mr. Long. Dr. Bailet, in your testimony you discussed

challenges faced by small, solo and rural practices also. Can you speak to your efforts to provide these critical access points of care with tools they can utilize to succeed, particularly through your clinically integrated network?

Dr. Bailet. Yes. In these smaller communities we philosophically believe the care is local and should be delivered locally as best it can. But there are times when patients have to leave these smaller communities to get specialty care.

So we spend a lot of time making sure that the physicians in these smaller towns and clinicians, because it's not just physicians, have the resources -- the support of a larger system.

We try to create virtual outreach. So we have TelePsych, for example, that we're offering these physicians. Again, for them to want to go into smaller communities they don't want to be an island.

They want to be connected to the physician community at large because, again, they want to -- they want to have these assets for their patients.

So the more we have these interconnected points with our patients whether it's TelePsych or we have TeleStroke, we can bring those attributes out to the community so these physicians in smaller communities feel like they have a team behind them to be able to manage the patients.

And yes, there are times when you have to convince the

patients to leave the community for their care. But we work very hard to return those patients as soon as possible, again, with that electronic record, with that team support so that the physicians who are treating these patients feel like they have a safety net to be able to manage them if there's a complication or additional questions that come -- that come up.

Mr. Long. Okay. I think I'm out of time so if I had any I'd yield it back.

Mr. Pitts. Chair thanks the gentleman. That concludes the question from members present. We're going to go to one follow-up per side. Chair recognizes Dr. Burgess five minutes for a follow-up question.

Mr. Burgess. Thank you, Mr. Chairman. This really has been a wonderful panel. I do feel obligated to mention since interoperability has come up so much this morning that yes, part of the effort in passing the H.R. 2 was to deal with that but then a larger effort is -- has been included in H.R. 6, which was the Cures for the 21st Century and that bill, of course, passed the House last summer and is pending before the Senate. So please don't think we've taken our eye off the ball on interoperability. It remains an important marker to achieve.

Dr. McLean, let me just ask you, and you all have been very thorough in your testimony today. But I'm always struck in dealing with the stupid SGR that it was the update adjustment

factor that really did violence to doctors.

Now, that's the conversion factor. You talk about every doctor gets their own -- can create their own conversion factor. And at the risk of being too wonky, can you kind of go through that at a high level so our friends in the press can get that?

Dr. McLean. No, no. I thank you very much. I'm very happy to answer that question. So I'm not certain how wonkish some of the committee is.

But when the Medicare physician fee schedule is calculated on a fee basis -- you know, it's fee for service -- there is every item, procedure, office visit, E&M code -- evaluation management code, as we call it -- has an RVU -- relative value unit -- kind of number and this is what the RUC works on, kind of changing and calculating year to year.

And that number, that RVU, is multiplied times a conversion factor every year to end up giving you kind of the dollars per visit for a -- whatever.

And that conversion factor was changed -- I mean, so with the SGR, depending upon what the SGR kind of kicked out as what the adjustment should be, that conversion factor for every service -- physician service was cut by a certain percentage to begin with and then because the can got kicked down the hill it kept going -- growing and growing. So it was, whatever, 28 percent in the -- at the end.

And so now it's effectively -- the conversion factor will be individualized based upon, for example, their MIPS score. So it's tremendously empowering to physicians to kind of think that if I'm actually doing a better job in some of these various quality measures and things, I will be judged myself for how I did.

And I think when we talked about burnout a little bit I think one of the -- one of the factors of burnout in addition to regulation and trying to deal with EMR and other changes is that financial anxiety and the fact that now at least they have control over that anxiety I think is huge.

Mr. Burgess. What is the -- you know, we talk about things being iatrogenic in health care. What would be the congressional equivalent of that? Because the anxiety -- much of the anxiety that many of you have spoken about this morning was actually generated by Congress or the agency.

It wasn't directed -- it wasn't generated by physicians or the practice of medicine. There's enough anxieties in the practice of medicine but we generated anxieties here.

Dr. Bailet, let me just ask you a question on that. We kind of covered some of the stuff with the physicians technical advisory committee.

But can you give us perhaps a bit of a sense of how this compares and contrasts with the Center for Medicare and Medicaid Innovation that was also -- is also one of the things that's been

visited upon physicians?

Dr. Bailet. The CMMI?

Mr. Burgess. Yes.

Dr. Bailet. Yes. So I think that the work that was done under CMMI was sort of planted the seeds of innovation and those kinds of models and our care designs that came out of that I believe they're going to be contributing to the innovation that's injected into the models that the PTAC will consider. I'm hoping I'm answering your question.

Mr. Burgess. Well, I guess the one philosophical difference that I see, CMMI is driven by the agency and it may or may not make sense to the practicing physicians.

PTAC is driven by docs.

Dr. Bailet. Yes.

Mr. Burgess. And my hope is that that will make sense to the practicing physician. Is that a fair assessment?

Dr. Bailet. Yes. It has to.

Mr. Burgess. Okay.

Dr. Bailet. And I think that I've heard and I can say -- speak for the committee to the individual level that is absolutely paramount and that is -- that is the desire of this committee.

Again, we respectfully understand that it is an independent body and an advisory body but absolutely, and we are -- we are doubling down on our efforts to listen to the stakeholders and,

frankly, our output is to some degree -- to a large degree going to be as good as the input of the stakeholders as they come forward.

Mr. Burgess. Much of this -- as the bill itself was into the development stages, stakeholders, especially groups' physicians, would come to us and say we've been doing this for a while and we think this is a good idea.

But we've got no way for CMS to -- no way to bring it to CMS and have them evaluate it and incorporate it. And now PTAC actually provides that avenue and, importantly, if it's not accepted people have to be told why it wasn't accepted and my hope is that will give them another opportunity to impact it.

Dr. Bailet. Resubmit. Right. And that is -- again, that is our plan to come up with a blueprint for people to be able to follow and to provide advice and guidance to allow resubmission if there are -- if there are challenges or potential weaknesses with their proposals.

And, again, we want to be as comprehensive and transparency is key here to make sure that once we get the feedback from the specialty communities and the other societies that we develop a model that is transparent and anybody wherever they are, wherever they are in their readiness and abilities can look at this and say look, I want to participate -- I want to create a model and they have -- they have the blueprint that then they can apply their potential proposal in order for the PTAC to critically evaluate

it and that is -- that is -- right now we are right in the middle of that -- developing that process of analysis.

Mr. Burgess. Great. That's the right answer. It gives me great peace.

Mr. Chairman, I would just say after well over ten years on this subcommittee one of my fondest wishes was to come in here someday and have a panel of doctors tell us how much economists should be paid. So if you all want to respond to that in writing I'll be happy to listen.

Mr. Pitts. All right. The chair thanks the gentleman and now recognize Mr. Green five minutes for questions follow-up.

Mr. Green. Thank you, Mr. Chairman.

Dr. Bailet, you brought up the potential impact of MACRA to transform patient care. Can you describe how you can see the APMs are beneficial to the -- to the patients?

Dr. Bailet. Well, I mean, these models are -- the underpinnings of these models are to impact patient care to provide high-quality care, enhanced patient care, obviously, with smarter spending.

But the elements in the models will be -- the underpinnings will be moving the quality spectrum forward to make sure that that outcomes, and that really is the point of the round here is the actual outcome.

You know, there are -- there are metrics A1C -- there are

targets that we -- that we strive for as a practice. But I also think what these APMs will be able to do across populations is actually look at outcomes, not just the fact that the diabetic patient has an A1C less than seven but what are some of the other parameters of their functionality, some of the other morbidity and mortality associated with the disease -- what are we actually changing their health status and being impactful and I believe the APMs will allow us to do that.

Mr. Green. Any of the other panel?

Dr. McAneny. Yes. I would like to add on that on a very personal experience because in participating in my oncology medical home process we've had -- in order to have that money from the innovation center come to us to be able to allow the practices to spend money on nurse educators who could teach patients what's going on, nurses doing triage on the phone.

We brought patients in, 15 to 20 same-day visits every day. We cut the rate of hospitalization for cancer patients by over half.

Patients were thrilled to be able to see us on the weekends and on the same day that they needed to see us. And so it was a very immediate way that we were providing patients because of this APM with the care that they needed when they needed it and where they could get it at a lower cost.

Mr. Green. Dr. Wergin.

Dr. Wergin. I just had a brief comment. Moving away from a face to face volume-based system to an APM will give you the resources that is focused on the patient and the patient-centered home it starts with the name patient, and that's what it means.

You focus on the patient, the care they need, when they need it and that's been addressed. So I think APMs can move not to just save money because I'm interested in that -- more importantly, I want to improve the health of the community I live in.

Dr. McLean. I was just going to add I think that moving -- the APMs incentivize physicians and physician groups to get into kind of systems or affiliations that allow them to, as I mentioned before, to deal with big data, and that big data is not just seeing how many people, you know, got their A1C done in six months.

But it's looking at well, the people who didn't what's different about them -- what happened -- why is this group of people not getting, you know, diabetic foot exams.

It allows people to kind of intervene and make a difference in health care and when you're in small kind of groups sometimes you don't have that big data to do and as I say people fall between the cracks and you don't even realize where the system is failing a lot of our patients.

There's less duplication, which saves money. Interoperability helps with that. I mean, it just -- it aligns

very many things into one kind of direction and that's really one of the major things we've been lacking.

Mr. Green. Okay. Thank you, Mr. Chairman. I yield back.

Mr. Pitts. Chair thanks the gentleman. That concludes the follow-up questions. We will have other follow-up questions in writing that we'll send to you and other members who aren't here will have some questions.

We'll ask you please to respond promptly. I remind members they have ten business days to submit questions for the record and that means they should submit their questions by the close of business on Tuesday, May the 3rd.

Excellent hearing, very thorough testimony. Really exciting and optimistic hearing today. We'll monitor closely this implementation. This is the second hearing. We will have more.

We look forward to working with you. Thank you very much for coming and presenting your testimony and expertise -- sharing your expertise with us.

Without objection, the subcommittee stands adjourned.

[Whereupon, at 12:09 p.m., the hearing was adjourned.]